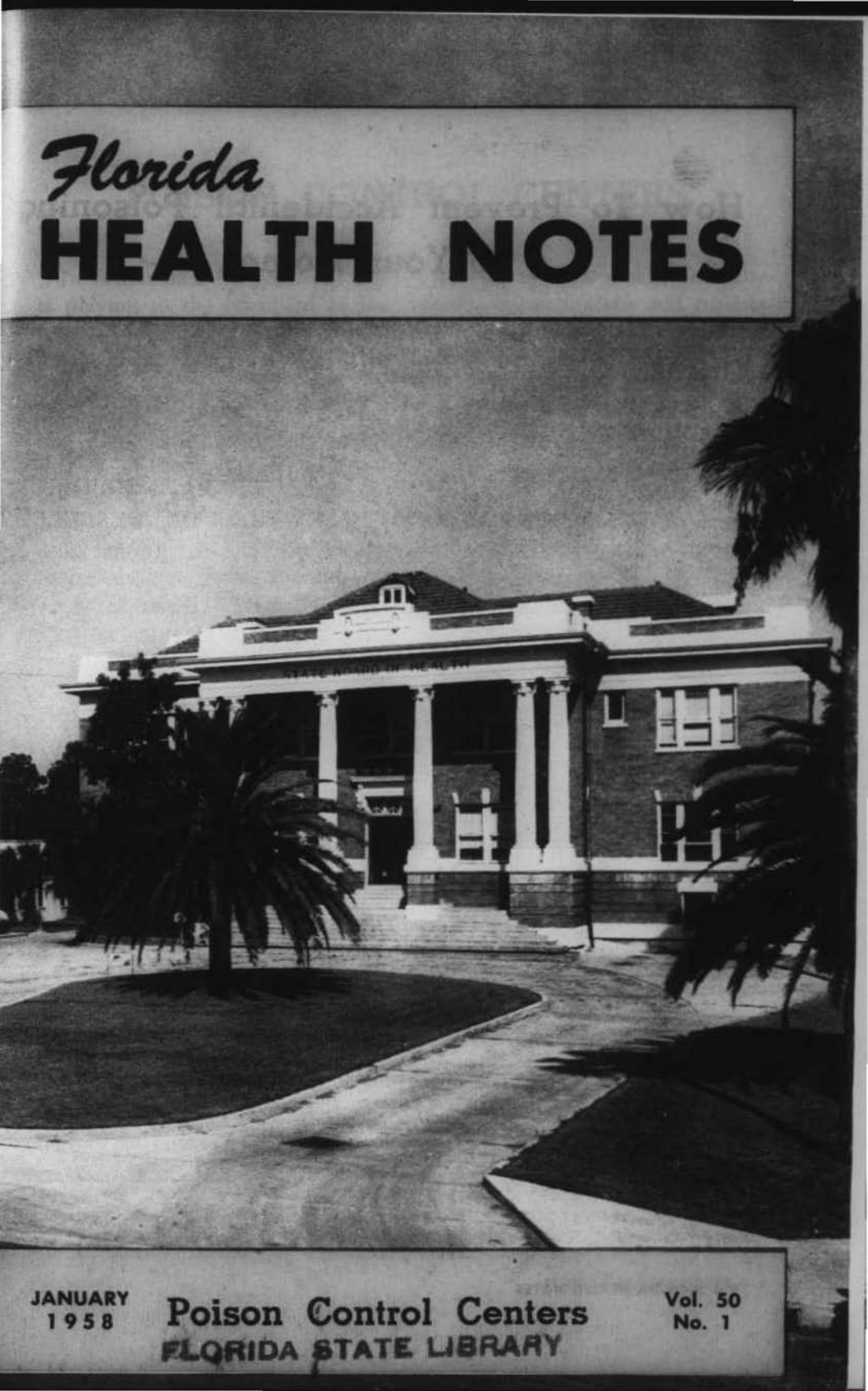
Florida
HEALTH NOTES



JANUARY
1958

Vol. 50
No. 1

Poison Control Centers

How To Prevent Accidental Poisoning In Your Home

KEEP ALL DRUGS, POISONOUS SUBSTANCES, AND HOUSEHOLD CHEMICALS OUT OF THE REACH OF CHILDREN AND UNDER LOCK AND KEY IF NECESSARY.

DO NOT STORE NONEDIBLE PRODUCTS IN THEIR ORIGINAL CONTAINERS; DO NOT TRANSFER THEM TO UNLABELED CONTAINERS.

WHEN MEDICINES ARE DISCARDED, DESTROY THEM. DO NOT THROW THEM WHERE THEY MIGHT BE REACHED BY CHILDREN OR PETS.

WHEN GIVING FLAVORED AND/OR BRIGHTLY COLORED MEDICINE TO CHILDREN, *ALWAYS* REFER TO IT AS MEDICINE – *NOT* AS CANDY.

DO NOT TAKE OR GIVE MEDICINE IN THE DARK.

READ LABELS BEFORE USING CHEMICAL PRODUCTS.

Health Notes is indebted to the American Medical Association for these simple rules and the "First Aid For Poisoning" directions given in the center spread of this issue. They have been digested from an article which appeared in the October 12, 1957 issue of the Journal of the American Medical Association.

POISON CONTROL CENTERS

In Pensacola a five year old boy is playing in the backyard of his home. Looking down he spies what appears to be a piece of candy. Popping it into his mouth he chews it up and the bitter taste makes him sick. He runs to his mother who immediately picks him up and takes him to the nearest doctor. When the doctor recognizes that the boy has been poisoned he questions the mother to learn what the child might have eaten. The mother thinks it must have been a pill her husband gave the dog for worms. The doctor lifts the phone and dials the number of the Baptist hospital in Pensacola. The doctor in the emergency room goes to the files and quickly tells the inquiring physician what poison ingredients are in the pill he suspects the child has eaten. With this information the doctor administers the proper antidote and the child returns home, shaken by his experience, but fully recovered.

In Osprey a 20 month old baby climbs up on a chair and reaches for a bottle of mineral spirits from which he takes a big swallow. His father rushes him to the Poison Control Center located in Sarasota Memorial Hospital. There he receives the proper treatment and is returned safely to his parents.

A box of mothballs lies partially open on the closet shelf in a Miami residence. One of the balls rolls out and falls to the floor. A three year old baby finds it and pops it into his mouth. At Jackson Memorial Hospital the emergency room files reveal that naphtha is the poison ingredient. The correct treatment is given as indicated on the file card. Another life is spared.

Over in Alachua a mother is in her bedroom changing her baby's diaper. In the next room the two year old daughter is climbing to a shelf where a bottle of aspirin attracts her attention. Before the mother finishes with the baby the

FLORIDA HEALTH NOTES

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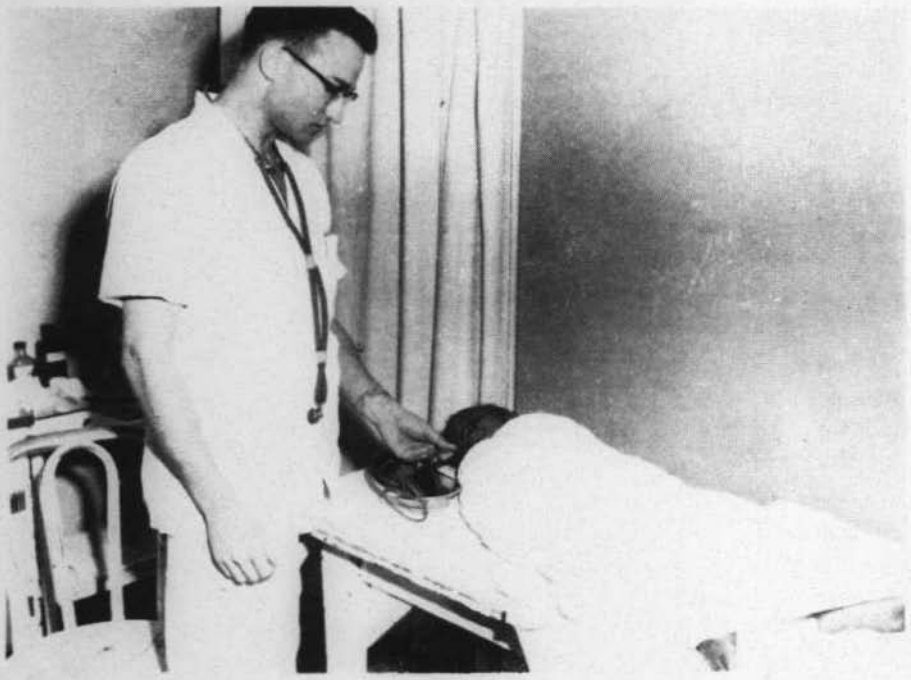

This two year old drank a glass of kerosene. An older brother drew the kerosene from a tank to remove shoe polish from his hands. When he was finished he sat the glass on the kitchen sink. The victim found it there and, thinking it was water, drank it down. Here the stomach is being lavaged (pumped out) to remove the contents. Further treatment was given as prescribed by the Poison Control Center files for kerosene poisoning.

little girl has eaten a handful of aspirin tablets. The Alachua General Hospital in Gainesville has all the necessary information on its files to provide the family doctor with the information about the treatment and antidotes. Another life saved by a Poison Control Center.

And so it goes from day to day. People from all walks and stations of life become victims of accidental poisoning. People just like you, or your neighbor who think they have taken all precautions to see that their children or other members of the family do not accidentally consume poisons. But even with

MEMORIAL HOSPITAL
PANAMA CITY
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more-than-usual precaution, accidental poisoning still occur.

Most of the cases concern small children. Babies in their early years are great experimenters. They seem determined to try out all their six senses, which include the sense of taste, on everything they can find. They are completely ignorant of danger and even under extremely careful parental attention, some of them still persist in getting into trouble.

For example: over in Archer, near Gainesville, a father bought a bottle of dry potash to use in a fertilizer mixture. Placing the container on the floor of his car he closed the doors and went into the house. A younger child opened the door and left it open while he went off to play. A sixteen month old baby climbed into the car, uncapped the bottle and ate some of the potash. A visit later by the public health nurse from the County Health Department revealed that the family was ordinarily very careful about keeping any form of dangerous products out of reach of the children. This was just another of those one-in-a-thousand cases where an unguarded moment brought trouble.

We all know, though, that carelessness breeds disaster. A four year old boy was treated at the Jackson Memorial Hospital in Miami after he had eaten poisonous "nuts" from a tree that grew in his yard. Subsequent examination revealed that the house was a virtual death trap. Frayed electric cords hung loosely all about the house and insecticides were mixed in with cans and boxes of food. Medicines were found on shelves low enough so that even the youngest child in the family could easily reach them if he wished to.

Poisoning Is Common

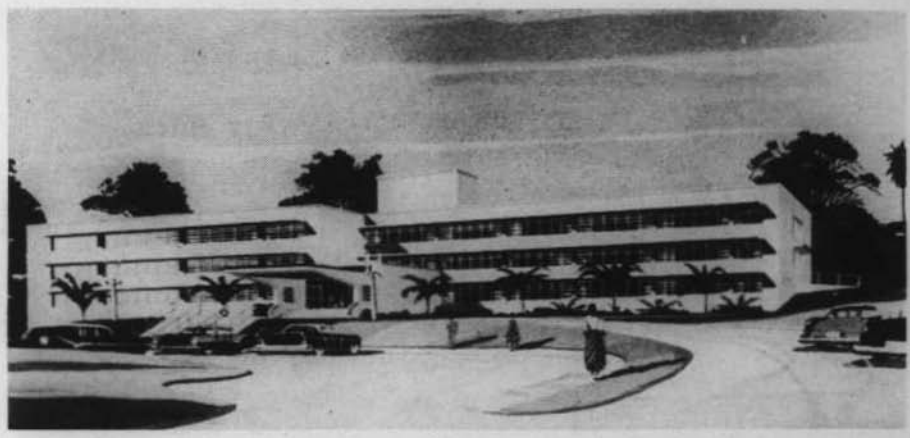
The files of the State Board of Health are filled with cases involving the eating or drinking of laundry bleach, roach poison, tranquilizer pills, aspirin, cosmetics, poisonous mushrooms, vodka, kerosene, and common household products such as ammonia and mineral spirits. The constant stream of cases reported made it important that something be done to help sovle the problem. It was decided to attack the problem on two fronts:

1. Through public information and education to emphasize the fact that accidental poisonings can be avoided with proper attention to small details, and

2. By creating a group of Poison Control Centers located strategically throughout Florida which would stand ready around the clock to cope with just such emergencies.

Obviously, the establishment of the Poison Control Centers was the first step, for public education takes time and work and children who were poisoned were being reported daily. Therefore, the tedious task of accumulating information on every known product that might be a potential poisoner was begun.

A first file was made up by the



MUNROE MEMORIAL HOSPITAL
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Accident Prevention Committee of the Florida Pediatric Society and the Florida Chapter of The American Academy of Pediatrics. It contained the trade names of products previous experience had shown were frequently involved in accidental poisonings. Next the chemical composition of the product was listed. The poisonous elements in the product were clearly defined so there would be no possibility of a mistake or any doubt as to the contents.

When this file was completed a second file was built up painstakingly. The cards in this second file showed the antidote or treatment required for each of the poison elements named in the many various products. Also included were all the latest procedures for handling each case.

When the files were completed a group of carefully selected reference books was purchased to accompany each set of files. The State Board of Health helped by furnishing some of the books, files, etc. needed to make the plans complete. Now all was in readiness to begin the operation of installing the Centers in various hospitals throughout the state.

The members of the Accident Prevention Committee of the Florida Pediatric Society and the Florida Chapter of The American Academy of Pediatrics, who had labored so diligently to bring the plan into being decided to approach the hospitals in their own home towns as a starting point to

ALACHUA GENERAL HOSPITAL
GAINESVILLE
FR 2 - 4321

installing the Centers throughout the state. Eventually it was hoped that all hospitals in major population centers would have sets of files and reference books. However, there were fifteen members on the Committee and they represented towns and cities from points strategically located throughout the state. Each returned to his own area with the plan which was received with complete cooperation by the hospitals to whom it was offered.

When all the Centers were established and ready for operation the doctors in the area were notified as to the location of the Centers and what they could do. The plan was very simple; if a patient was brought to a doctor's office he was to try to learn the trade name of the product involved. Picking up his phone he was to contact the nearest Poison Control Center. After giving them the information, he was, in turn, to be advised concerning the poison involved, the treat-

ment and the antidote. Immediate treatment could be administered and the patient could be saved many hours of suffering and possible permanent injury or death simply because it was not necessary for the doctor to make exhaustive tests or inquiries to determine the nature of the poisoning before administering the treatment.

In cases of severe poisoning, such as lye poisoning or the drinking of kerosene, the victim was rushed to the nearest Poison Control Center for additional treatment after the doctor had administered first aid as prescribed by the file system. Lye, in particular, can leave the patient with very severe scar tissue in the throat and esophagus (stomach tube) as a result of the burning of the delicate tissue by the caustic action of the lye. Naturally, these patients require much more extentive treatment than poisonings of a less severe nature. In practically all cases, hospitalization is necessary following poisoning by taking lye or kerosene through the mouth.

After informing the local doctors of the plan and the location of the Centers the next step was to inform city, county and state police officers of their existence and to explain to them how the Centers were to be used. In many cases it is a

BAPTIST HOSPITAL
PENSACOLA
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FIRST AID FO

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WHILE WAITING FOR HELP

1. MAKE THE PATIENT VOMIT UP THE POISON IN ALL CASES.
   EXCEPT:
   - When he is unconscious or in a coma.
   - If the victim is having convulsions.
   - If the victim has swaled petroleum products (gasoline, kerosene lighter fluid, naptha, etc.)
   - If the victim has swallowed a corrosive poison (toilet bowl cleaner, sulfuric nitric or oxalic acids, rust removers, styptic pencil, drain cleaners, washing soda, ammonia water, household bleach, etc.)
2. KEEP THE VICTIM FROM BEING CHILLED. Wrap in blankets or use hot water bottles if necessary.
3. DO NOT GIVE ALCOHOL IN ANY FORM.
4. WHEN VOMITING BEGINS, PLACE VICTIM WITH HEAD LOWER THAN HIPS AND FACE DOWN. (This keeps poison from getting into the lungs and doing further damage).

The following si
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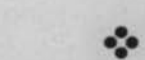

IF THE VICTIM'S SKIN HAS BEEN CONTAMINATED

1. Drench skin with water (shower, hose or faucet.)
2. Apply stream of water on skin while removing clothing.
3. Cleanse skin thoroughly with water (rapidity in washing is most important in reducing extent of injury).

IF THE VICTIM'S EYES HAVE BEEN CONTAMINATED BY POISON

1. Hold eyelids open, wash eyes with gentle stream of running water *immediately.* Delay of a few seconds greatly increases extent of injury.
2. Continue washing until the physician arrives.
3 *USE nothing but water.* Chemical eyewashes, etc., may increase the extent of the injury.

IF THE VICTIM HAS BEEN BURNED BY CHEMICALS

1. Wash with large quantities of running water.
2. Immediately cover with loosely applied clean cloth.
3. *Do not use any ointments, greases, powders, or other drugs in treatment of chemical burns.*
4. Keep victim flat, and keep him warm until medical help arrives.

SARASOTA MEMORIAL HOSPITAL
SARASOTA
RI 6 - 1181

police officer that brings the victim to the Control Center or to the nearest doctor. Sometimes, by using their radios the officers have been able to have the information in the hands of the family physician by the time they arrive with the victim.

Doctors have expressed themselves as being highly pleased with the program. They feel that valuable time in getting the right treatment started for the patient is saved and that this has already resulted in saving many lives that might otherwise have been lost. In addition, the program has aroused interest, especially among parents as to the necessity for the better methods of prevention of accidental poisoning. More people are now aware of the need for greater care in handling and storing dangerous, or even common, household substances.

As time goes by the number of Centers over the state will undoubtedly grow. Physicians are more and more depending on them for vital information and as such information is added to the files, they will become more valuable to the public. In fact, based on the results of the first year of operation it has even been suggested that legislation be passed requiring manufacturers to furnish additional information regarding the elements in their products, and that such information be placed on the label where it can be easily read.

Does Florida Have Many Poisoning Problems?

Well, let's see what the first year of operation showed. It must be borne in mind that the results we are looking at in the following paragraphs represent only the cases reported to the State Board of Health. Many cases were handled which were not reported due to various circumstances. No record is made of cases where a doctor phones the Center for information and administers treatment in his office. Also, due to the press of other duties it is not always possible for the County Health Departments to follow up on cases reported. These and many other factors affect the reports on file but the results are still imposing and will be of much interest.

The fifteen original Centers, in cooperation with the Florida Pediatric Society, The Florida Chapter American Academy of Pediatrics, the Florida State Board of Health and the fifteen County Health Departments involved, reported a total of 736 cases of accidental poisoning between July 1956 and July 1957. This figure does not include the many hundreds of telephone calls from doctors and patients requesting information for persons not coming to the Centers for treatment.

The poisons taken makes an imposing list and includes items not generally considered to be poisonous. However, the greatest number of cases were results of the accidental taking of internal medicines.

Right here it should be pointed out that of the 736 cases reported, 575 of them were accidental; 73 cases were attempted suicides; 60

resulted from unintentional overdoses, and 28 are unknown or undetermined. Therefore, with only ten per cent of the cases resulting from an intentional effort to take one's own life we will confine this issue of *Florida Health Notes* to accidental poisoning.

Of the 307 cases involving internal medicine, the taking of excessive amounts of aspirin leads all the rest. There were 129 aspirin cases; 56 involving barbiturates (sleeping pills); 32 cases involving other sedatives and relaxants, and 11 cases resulting from overdoses of laxatives. The remaining 79 cases involve a number of medicines of various types.

Certain other miscellaneous substances, ordinarily given little thought as potential poisoners, was next highest on the list of cases with 173 reported. Of this group, cleaning agents led the list with 81 cases. Turpentine followed with 13 cases. There were nine cases reported involving the eating of poisonous toadstools; six cases where tung nuts were involved; cosmetics accounted for five cases, and various other items involved the remaining 59 cases listed under this category.

Third place fell to the petroleum products. In this group we find a total of 113 cases reported with kerosene involved in 87 cases, gaso-

line accounting for 12 cases and the balance, 14 cases, resulting from motor oil or other products of a similar nature.

Strangely enough, insecticides, although they are known to contain many different types of poisoning agents, rank next to the bottom in causes of accidental poisoning with only 105 cases reported.

Roach poison was involved in 42 cases, rat poison was the substance reported in 12 cases, closely followed by ant poison with 11 cases. Parathion, chlordane and DDT, or combinations of these three chemicals only accounted for seven cases and other substances of various kinds made up the balance of 33 cases. It is curious to note that the public, being generally aware of the poisonous content of these substances has probably made a stronger effort to protect children from accidentally taking them.

Last on the list of poisons are medicines for external use only but which are swallowed by the victims. Heading the list is iodine with 12 cases reported; alcohol resulting in seven cases; camphor, seven cases, and other external medicines, 12 cases, making a total of 38 poisonings resulting from this cause.

White females lead the list of individuals involved with 304 of the 736 cases reported. But the men cannot be too pround, for white males followed closely with 289 cases. Colored males were involved in 59 cases as compared with 52 colored females. There were 32 cases reported which did not indicate the sex of the victim.

Most Cases Reported Among Younger Children

Younger children are by far the most likely to become involved in accidental poisoning. A check of the cases reported shows that the chief group of victims fell in the age group of one to four. Of the 736 cases reported, 530 of them were children under five years of age. Strangely enough, the next five years of life shows a marked decrease, undoubtedly because children of this age are in school and are not subjected to the same hazards as the crawling and toddling youngsters still at home with mother. In the five to nine age group only 33 cases were reported.

In children age 10 to 14 only five cases were reported. But here the figure again begins to rise with 13 cases reported among the 15 to 19 year olds, and 127 cases reported involving people over 20 years of age. The 73 attempted suicides, mostly females, fall in this latter age group and presumably resulted from emotional stress or upset. In many instances these victims were referred to Mental health clinics for assistance and their problems were cleared up so they could again take up a normal life without desiring to again attempt to "end it all." This is just an added benefit resulting from installation of the Poison Control Centers.

LEE MEMORIAL HOSPITAL
FT. MYERS
ED 2-1141

Who Was Watching the Child?

Of 280 cases reported, mother was the person watching the child in the majority of cases, 227 of them, in fact. Grandparents were taking care of the children in 28 cases, while 11 reported that an older brother or sister was watching them. Maids and baby sitters accounted for five cases and this figure is the same for children being watched by a family friend. The father is listed as the responsible person in only four of the cases reported. However, the father spends very little of his time with the children as compared with the mother (lest there be some feeling that mommy is not as watchful as daddy).

The figures below show the number of cases reported by the Poison Control Centers between July 1956 and July 1957.

Miami	189
Jacksonville	166
Pensacola	79
Gainesville	68
Tampa	52
Sarasota	37
Panama City	36
Ft. Lauderdale	32
West Palm Beach	18
Fort Myers	17
Ocala	18
Lakeland	13
Orlando	5
Daytona Beach	2
Tallahassee	0
Unknown	4

The Poison Control Centers' plan was first organized in Illinois in 1952. Several other states followed after about two years. With very few exceptions the centers were established in emergency rooms of leading hospitals located as strategically as possible so that quick attention could be given to any cases reported to them.

Today seventeen states have adopted a plan and put it into operation. Undoubtedly more states will follow very soon. Although it is too early to provide any suitable statistics as to the success of the plans, it is a well known and accepted fact that many lives have been saved through quick attention provided by the centers that might have been lost otherwise.

Although there are hundreds of thousands of non-fatal cases of accidental poisoning, the 1952 calculation, nation-wide, shows that there were 1,440 cases where the death certificate gave accidental poisoning as the cause of death. This is more deaths than were recorded in the same year from such formerly dreaded diseases as typhoid fever, malaria, scarlet fever, smallpox and whooping cough combined. Therefore, accidental poisoning became one of the most important projects for the year and the Poison Control Centers resulted from the studies and effort of the pediatricians and physicians.

Florida leads the nation in number of centers — there are at present sixteen centers in operation with more to be added in the near future.

Pictures of the following Poison Control Centers were not received before press time:

CITY	HOSPITAL	PHONE NO.
Ft. Lauderdale	NORTH BROWARD GENERAL	JA 2 - 3611
West Palm Beach	GOOD SAMARITAN	TE 3 - 1741
Tampa	TAMPA GENERAL	8 - 4321
Lakeland	MORRELL MEMORIAL	MU 4 - 4211
Daytona Beach	HALIFAX DISTRICT	CL 2 - 5561
Orlando	ORANGE MEMORIAL	3 - 5511
Jacksonville	DUVAL MEDICAL CENTER	EL 3 - 3631

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Bureau of Entomology
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All Counties in Florida have organized county health departments, except St. Johns County

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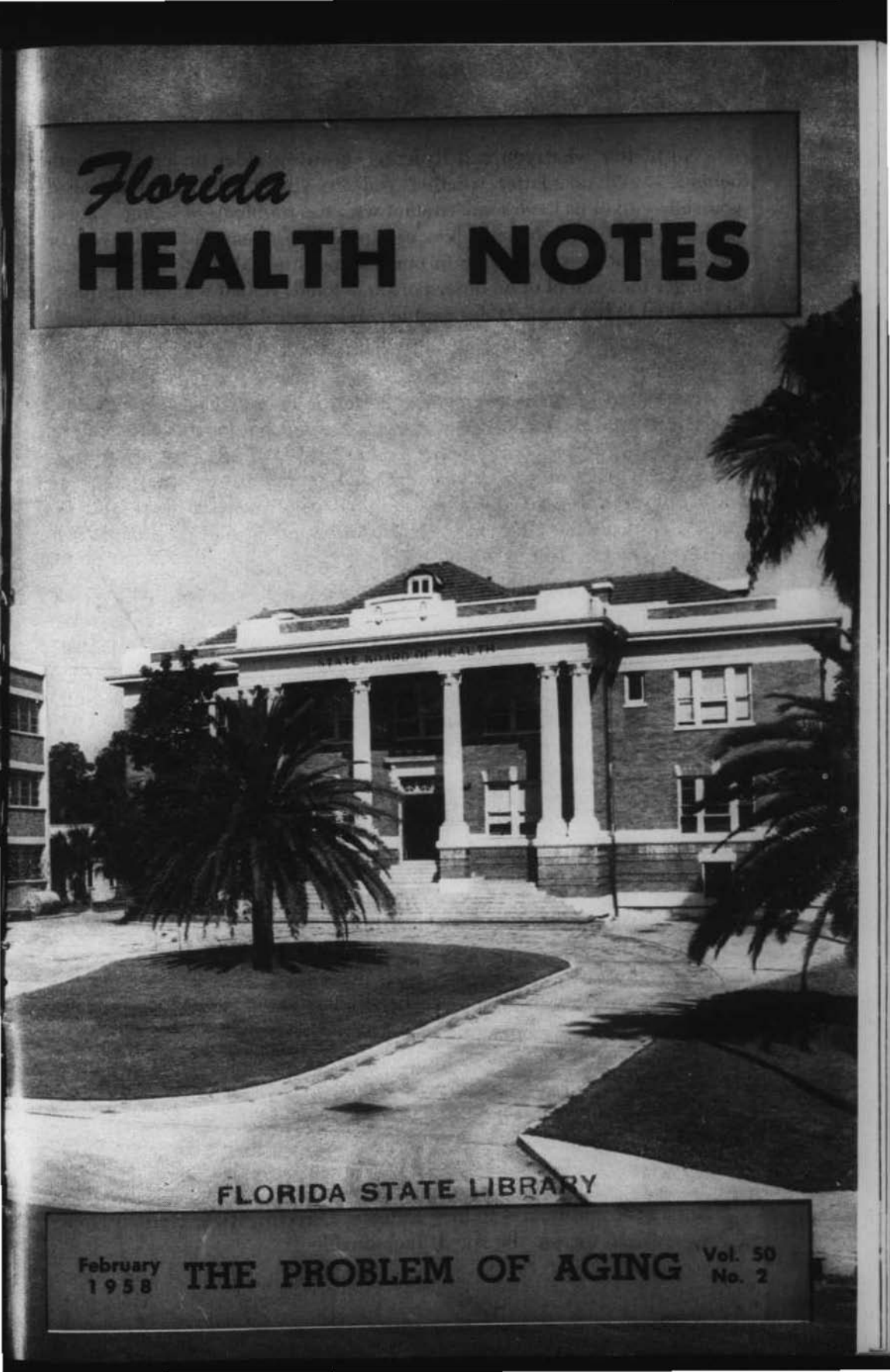
Florida HEALTH NOTES



February 1958 Vol. 50 No. 2

THE PROBLEM OF AGING

No matter what you call it: aging, growing older or leaving youth behind – and no matter whether you are young, old or middle-aged yourself – all of us have some contact with the problems of aging. These problems may concern ourselves or our aging parents and relatives, or the "senior citizens" who live in our communities. Whistler's mother is no longer the symbol of an older person – hands folded and sitting quietly resigned to her fate. Older people can be useful, happy, healthy, well-adjusted persons, *if* we face our problems realistically and do something about them.

At the 1957 annual meeting of the Florida Public Health Association, 12 experts gave their opinions about what could be done about some of the problems older people face. We have taken the liberty of "lifting" some of the ideas from their talks for your thoughtful consideration. If you would like to read any of the original papers, please write and request them from the Division of Health Information, Florida State Board of Health, Jacksonville, Florida.

The experts and their papers which were the basis for this issue of Florida Health Notes are:

General Statistics – Robert M. Thorner, Bureau of Vital Statistics, State Board of Health

Nutritional Problems – May McBath, Regional Nutritionist Consultant, State Board of Health

Nursing Problems – Ferne Britt, R.N., Nurse Consultant, State Board of Health

Medical Problems in Later Years – Louis L. Amato, M.D., Medical Director, Fort Lauderdale Beach Hospital

Mental Aspects – Melvin P. Reid, Ph.D., Acting Director of Bureau of Mental Health, State Board of Health

Research Studies – Michael J. Takos, M.D., Director of Research and Special Studies, Dade County Health Department.

Religious Aspects – James A. Stewart, D.D., Dean of Chapel, Stetson University

Community Responsibilities – J. M. Buck, Mgr., Retirement System, Florida Development Commission

Rehabilitation – Claud M. Andrews, Director of Vocational Rehabilitation, State Department of Education

Social Services – Margaret Jacks, Director, Old Age Assistance to the Blind, State Department of Public Welfare

Employment of the Aged – Henry E. Richards, State Employment Service, Florida Industrial Commission

Nursing Home Role – Sidney Entman, Director, River Garden Hebrew Home for the Aged, Jacksonville

THE PROBLEM OF AGING

Facts and Figures About Older People in Florida

In any discussion of the problems of the aging it is best to learn first what the situation is regarding the number of older people in Florida, the proportion of the aged to people of other ages, whether the number is increasing or decreasing as time goes by, and what the relation of Florida's "senior citizen" is to that of the nation as a whole.

Our older population is generally referred to as those who are 65 years of age or older. This is an arbitrary limit since some people are old at 50 and others are not old in a physical sense until they reach their seventies or eighties. But 65 has been generally adopted as the retirement age by government and industry and therefore we use it as a basis of our figures.

The *number* of older persons in the state is probably the most important figure since the amount of social services, care and rehabilitation needed, nursing homes, hospitals and the like, depends on the number of older people and not on the proportion of the population that is over 65.

FLORIDA HEALTH NOTES

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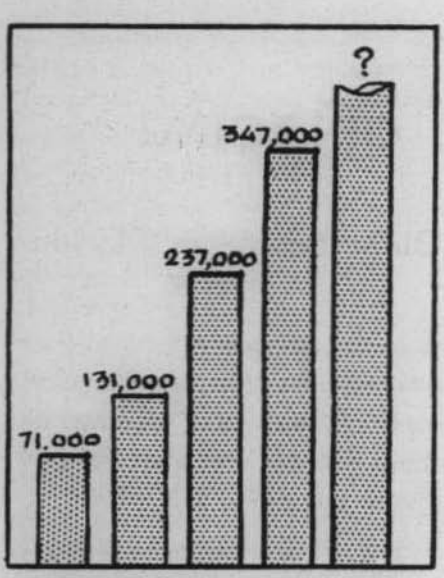
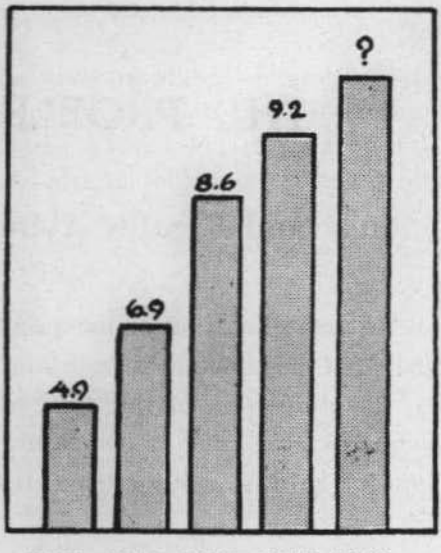


NUMBER OF FLORIDA PEOPLE OVER 65



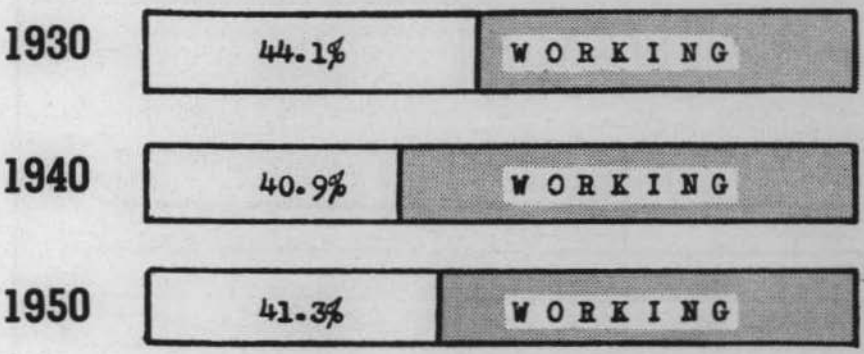
PERCENTAGE OF FLORIDA PEOPLE OVER 65

We can see from this graph that the number of older people has been steadily increasing. The percentage graph shows us, however, that even though the total number of persons has increased nearly five times since 1930 there is little more than double the percentage of population falling into the over-65 group during the same period.

Since the increase in number of older people is about 5.7 per cent a year it means that we must anticipate an increase in our services to the elderly by the same amount each year. We must provide this much *more* nursing services, medical care, rehabilitation and financial aid.

At this point it might be well to divide the population into two groups which will illustrate certain economic aspects affected by the changing age picture. One group is the working population, which is defined as the group between the ages of 20 and 65. The second group includes those below the age of 20 and above the age of 65.

For simplicity let us assume that everyone in our economy lives from the current production of goods and services, therefore, the proportion of persons in the non-working group is a measure of the relative burden of this group on the working population.



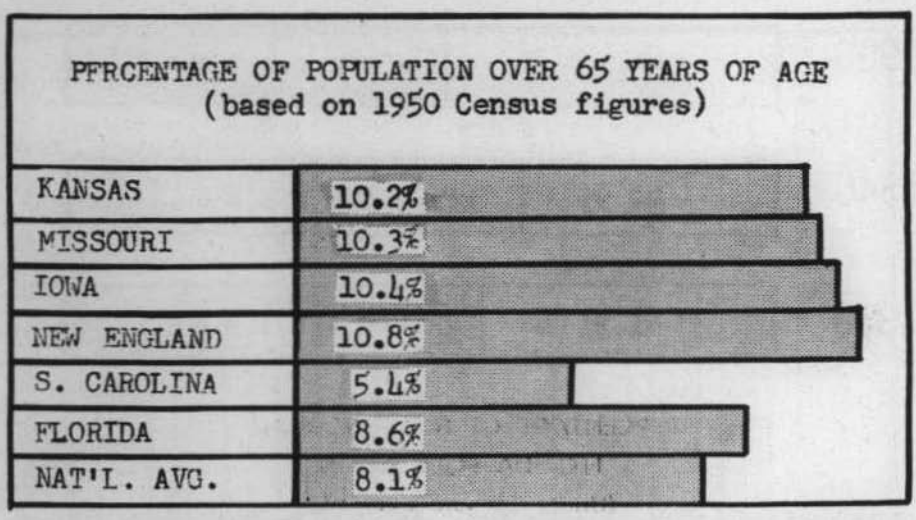
PERCENTAGE OF NON-WORKING
FLORIDA POPULATION
(Under 30 and over 65)

The above graph indicates that the percentage of non-working people fell slightly in 1940 from the 1930 figure. This was due to the low birth rates of the 1930's which offset the increasing proportion of older people during the same period. The effects of the high postwar birth rates were only beginning to be felt by the 1950 census. However, during the current ten year period the high birth rates are substantially affecting these figures and the 1960 census figures will show a marked increase in the non-working population.

Nationwide, the percentage of population was estimated to be 45.0 per cent. By 1965 it is expected to be about 47 to 49 per cent. *This means that in the near future about half our population will be depenent upon the other half for support.* Furthermore, this means there is a sort of "competition" between young children and old people for the use of the tax dollar: for schools, child health services, etc., as against old age assistance payments, health programs for the aged, and the like.

How does Florida's older population compare with the nation as a whole and with other states? Contrary to popular belief, Florida is not necessarily the land of older people.

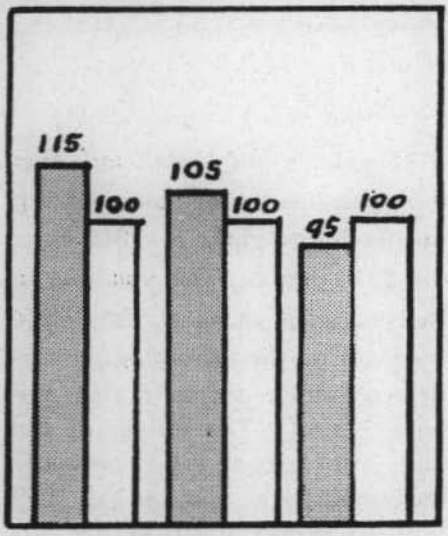
It can easily be seen from the next bar graph that there are several areas that have a larger percentage of older people than Florida.



Actually, nineteen states have larger percentages than Florida and the nationwide average is only slightly lower than ours.

Compared with other southern states, however, Florida has a larger percentage of older people. Migration into Florida is not, contrary to popular belief, an "in-movement" of elderly people. Working age people and their families have constituted the bulk of the population gain due to migration.

A final comparison concerns the number of males to females over age 65. The above graph shows that in 1930 there were 115 males to each 100 females over 65 years of age. This ratio has steadily declined until now there are fewer males than females. This is explained by the fact that in recent years the rate of death has declined steadily, but the rate of decline has been more rapid for females than for males. We can only guess whether the rate will continue in the future as it is now going. What is important, however, is the fact that if we have a greater number of females than males among our older population, we will have to plan our services on that basis.



PERCENTAGE OF MALES
TO FEMALES OVER 65
(Shaded Areas - Females)

MEDICAL PROBLEMS IN THE AGING

The progress of medical science has now made is possible for old age to be enjoyed by most of the people rather than a small minority. The pediatricians have learned how to save more and more children and thus make it possible for the ranks of our elderly people to be swelled by the addition of their numbers. However, when a person reaches 65 he has a normal life expectancy of 12 years which is the same as it was fifty years ago. Therefore, the problem is one of finding a cure for the diseases that are chronic in elderly people and which result from a gradual wearing down of the body through the years.

When older people become ill it takes their bodies much longer to repair and this means longer periods in the hospitals and longer periods of convalescence than with younger people. Actually, all too frequently the disease has been neglected and this accounts for much of the hospitalization of elderly people.

Unlike a machine the body is capable, to a limited degree, of repairing itself as time goes by. Nevertheless, time takes its toll in wear and stress on the tissues and organs and the functions of the various organs gradually slows down. Another factor affecting the health of elderly people is the accumulation of the "battle scars of a long life." Each illness or accident has made its mark on the body and the longer one lives the more of these "scars" he accumulates.

As we grow older we are more apt to fall prey to certain diseases and conditions. They are as follows:

Neurological (nervous system) and mental diseases

Diseases of the heart and blood vessels, such as high blood pressure, hardening of the arteries, etc.

Tumors and growths, both cancerous and non-malignant

Accidents

Nutritional conditions such as overweight, underweight and vitamin deficiences

Muscular-skeletal disorders chief of which would be arthritis and rheumatism

Infections, of which TB would be the most important

Preventive geriatrics (that branch of medical science which is concerned with old age and its diseases) in its broadest sense is the practice of medicine applied to a special age group, quite similar to pediatrics. Changes commonly regarded as the result of age are evidences of what the patient has lived with all his life. In reality,

they are the sum total of his experiences with health and disease. Perhaps what we need is a life "medical passport" which would be a record of all the illnesses and physical examinations which the patient has had throughout life.

The older patient is an individual with more social, emotional and economic problems than medical problems. He is faced with maintenance of health, of income, and of making social adjustments, at a time when he is less able to cope with them. Health is a central factor in every aspect of his life. It cuts across every social, economic and occupational line.

We simply haven't begun to apply the knowledge already available about how to help our older people. We must emphasize restoration of the bed-bound to self-care. There should be more health maintenance clinics, home care programs, well-oldsters clinics (similar to the well-baby clinics), counseling clinics, expansion of home nursing care, and extension of home care supervised by a hospital.

As a group, our aged are easy prey to the exaggerated claims made by various groups peddling miraculous remedies for their ills. If we provided a program as mentioned in the paragraph above, how much needless suffering would be avoided.

Florida Health Notes acknowledges with deep appreciation the assistance given by the residents of Moosehaven at Orange Park for their kindness in allowing pictures to illustrate portions of this issue. Pictures appearing on pages 30, 33 and 39 were made at this home for retired members of the Loyal Order of Moose.

THE ROLE OF THE NURSING HOME TODAY

The Nursing Home today is recognized as a vital and essential service in the care of older people. The good nursing home supplements the general hospital in serving those patients who no longer require the intensive treatment for which hospitals are geared. In addition, the financial cost in maintaining care for these people is greatly reduced.

It is curious to note that an analysis of the reasons why people send their relatives to nursing homes points more to differences in family relationships rather than illness. However, the great majority of older people are living at home or with their families as compared to the number who are placed in nursing homes. Therefore the biggest difference between the patient in the nursing home and the patient residing in his own home or with his children is not found in the degree of disability or need for intensive nursing service but in the family situation itself.

Families grow up and separate, the children going about making their own homes or careers. In many instances the parents are separated from the children by hundreds of miles. Then when disability or illness strikes they are brought together again. This sometimes creates differences in interests, variations in opinions, and all too often, outright friction. Unless these differences are more than offset by love, devotion and concern, the situation becomes such that a separation is necessary and the nursing home is the best answer.

There is another group of patients who are practically alone in the world. These are the unmarried people; those who have no children, and actually have no one they can call their own. These are truly the lonely people and when a crisis does occur, have no other place to turn to than the nursing home.

This then is our nursing home patient. He may be a combination of poor physical health, some mental decline, rejected by his own family, frustrated because he can't quite understand what the outcome will be, and in general a very unhappy and frightened individual. So very often we find it is not the disease or disability itself which is so disabling but the way the patient views his handicap, and how he uses it as a weapon to punish his family and/or society for what has happened to him.

Operators of well managed nursing homes realize that the patient is a person with feelings and emotions

as well as needs for medicines and attention, and work toward developing a spirit of contentment and "belonging" among the patients.

For this reason the task of staffing a nursing home is extremely important. Everyone along the line —nurses, porters, cooks—must have a genuine desire to help these people who are trusted to their care. Patience and understanding are valuable assets. The cook must realize the value of well-cooked, appetizing and balanced meals. The porter must learn not to display annoyance when feeble hands spill and drop. The nurse must sift the imaginary pain from the real one. And with it all the patient must be made to feel that he is important, wanted and loved.

One of the most difficult feelings to keep down among older people is the feeling of defeatism and indifference. In so many nursing homes the patients seem to be just sitting and waiting for a merciful death to relieve them of the boredom of daily living. This can be abolished by setting up a warm emotional climate where the patients are encouraged to participate in recreation such as games, bingo and community singing, and group activities such as religious services, clubs, etc. Arts and crafts should be encouraged to revive old skills and develop new ones. Successful performance of even minor skills are gratifying to the patient and boost his morale.

There are many community groups who can help people in nursing homes. The American Red Cross has developed a few pilot projects of placing "Gray Ladies" (hospital service volunteers) in nursing homes and homes for the aged. Early reports show enthusiastic response of the patients to the warm and friendly services of these ladies.

The nursing home operator must always be conscious of the fact that no matter how good his home is he is still providing merely a substitute for the home life of the patient. It can be a good substitute or a shoddy one, depending upon the interest and enthusiasm with which the operator and his staff view the patients.

NURSING HOMES FROM A NURSES POINT OF VIEW

Every nursing home should have a professional nurse (R.N.) either on their staff or to come in at regular times to supervise the nursing care. Many nursing homes in Florida today employ practical nurses and some of them were licensed on the basis of experience (under a waiver several years ago) and have had no formal education about illness, nor any training under the supervision of a professional nurse. Elderly people need expert as well as loving care if they are ill, just the same as a person of any other age. In many counties, a public health nurse from the County Health Department visits these homes occasionally – but not enough to supervise the proper care of the patients.

When a person is admitted to a nursing home he should be interviewed about his past illnesses; what he can and cannot do for himself; if he can control his bladder and bowels; if he has a hearing defect; what are his likes and dislikes. This last should give some kind of a clue as to whom he might room with when there is more than one patient in a room.

A doctor should examine the person when he comes into the home and no medicine should be given without his orders. Unfortunately, some nursing home operators have been known to diagnose and treat their elderly residents' ills and aches, even to the point of giving heart stimulants. Often elderly people do not want to eat properly and the good nursing home operator will alert the attending doctor before the patient becomes too weak or undernourished.

An X-ray of the chest is now a requirement for every patient who enters a nursing home. There is more tuberculosis in older people than in younger ones these days and one person with this disease could spread it to many more if it is not caught in time. And yet, there are some operators of nursing homes who object to having this done for their patients!

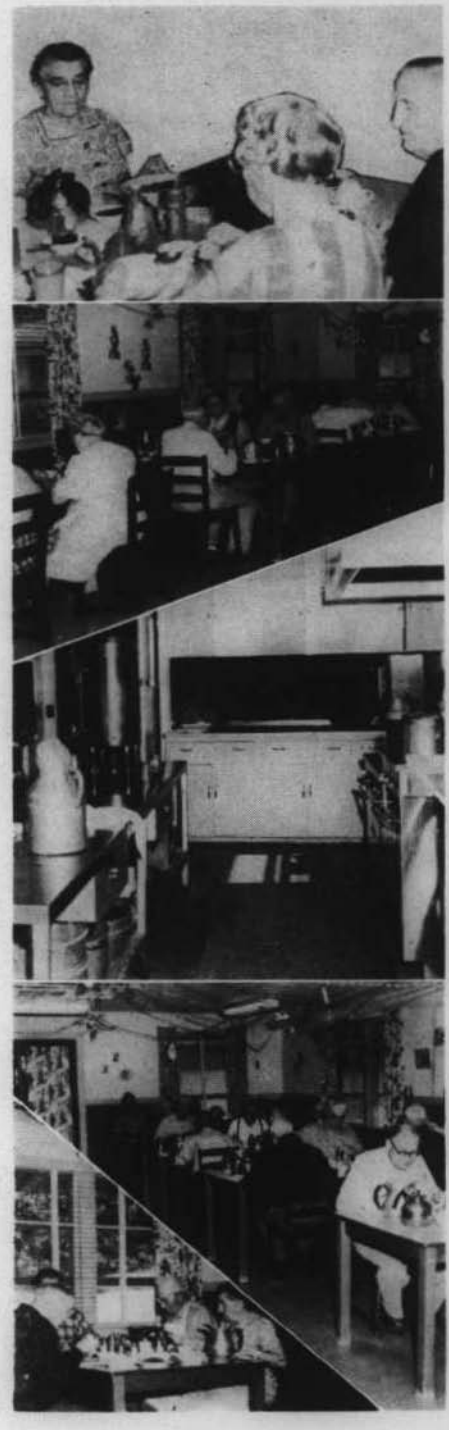
All nurses need to be alert to the emotional needs of their patients. The basic needs for elderly people is the same as for any other age: they need to be loved and wanted. They fear:

Rejection
Loss of economic security
Becoming dependent on others because of a disabling condition
Disfigurement or crippling
Pain and suffering
Death

Recreational facilities in the community should be utilized by the nursing home operator. Some operators look with suspicion upon anyone from the outside who offers to come in and assist with recreation for the residents; they are afraid they have come to spy and criticize – and perhaps this has been true in some instances. Older people like to play games and be amused, the same as any other age.

There are other things needed, too:

- Doctors who will visit nursing homes regularly to check on patients. When inspections were first made of nursing homes, after the compulsory licensing law was passed a few years ago, patients in some nursing homes had not seen a doctor in two or three years.
- We need to know how many and what kind of accidents are happening in these homes and how they can be prevented.
- A better educational program for the operators and their staff is needed. Such a simple thing as properly cleaning a thermometer needs to be taught to some "nurses" who give care. Important, too, is knowledge–like how to quickly get patients out of a burning house. These and many other ideas and techniques relating to better care of patients should be taught.
- Better records on patients should be kept. Doctors should have them available if needed; sometimes they might be needed as evidence in court. Records give clues as to the patient's care and the nurses's stewardship.



EATING HABITS OF OLDER PEOPLE

How much do we really know about the eating habits of older people? For years many symptoms of old age, such as general weakness and certain skin changes, have been regarded as symptoms of senility. Now, however, nutritionists are beginning to question them. Older people's nutritional needs do not seem to be basically different from those of other adult groups.

To make a dent in the mountain of information we do *not* have about the eating habits of older citizens, three studies were undertaken.

The first study asked restaurant owners their opinion of the eating habits of older people. Another survey was a diet record for one day's meals kept by visiting nurses on their patients and a health educator who picked people over 60 at random. The third study was to check trays at two cafeterias, (by the public health and Dairy Council nutritionists), and grade the meals as good, fair or poor.

Most restaurant owners were too busy to give a complete answer. They said older people ate well, but too large servings. Others who took more time had different opinions.

They felt that vegetables and fruits were neglected. Two operators said their customers ate a balanced diet because the menu was planned that way and there was no other choice. One of these, a dietician, explained that in order to keep the price low and serve a variety of high quality food, she served small portions. Consequently, some older people have eaten there daily for many years. These same two interested restaurant operators felt that people who ate in cafeterias did not choose well because servings are too large. This makes a complete meal rather expensive and means the customer must waste about half the food or overeat.

The diet records showed that most older people always eat bread and cereal. Protein foods such as meat, eggs, fish and cheese were usually eaten by the majority; with 86 per cent having some of these items. Apparently though, a poor choice is made of fruits and vegetables. Only 26 per cent had a citrus fruit or a substitute, and 42 per cent ate a green or yellow vegetable. These questions now arise; how can we "sell" vegetables and fruits as well as we have sold meat and like products? Is there a prejudice against citrus fruits as being "acid"? If so, what educational methods can be used to show this isn't so? The less valuable vegetables and fruits, indicated on the basic seven charts and "other fruits and vegetables" were eaten, for 92 per cent consumed at least one serving of these.

Milk, in the amount of two glasses a day as recommended, was taken by only 22 per cent of those asked. Most older people do not think milk is necessary for a complete day's meal plan. What can we do to increase milk consumption in this age group? Some nutrition workers have suggested that the older person needs more high calcium foods than the middle aged adult. The one day diet record made of 50 people showed that those visited by the Visiting Nurses Association ate better than those picked at random. Is it true that a person who does something about his illness, that is, seeks the help of a visiting nurse, would also be more selective concerning his food?

The question was asked, "What do you think is a balanced diet?" Very few people, only 12 per cent, could answer this. Most of those questioned consume a good breakfast, and are making a conscious effort to eat what is "good for them." To the question, "What food do you think does most for your health?", meat or protein food was the popular answer.

Checking trays in the cafeterias showed that older people come to breakfast early and eat a better breakfast than middle aged or

younger ones; 27 per cent had a good breakfast; 57 per cent fair and 16 per cent poor. We wondered if this was a habit established in their youth, before our rushing-off-to-work routine became common. Lunch was not as good; only 10 per cent selected a good lunch; 45 per cent were fair; the same number had poor lunches. Dinner fared some better, showing 24 per cent choosing a dinner graded good; 48 per cent fair and 28 per cent were poor.

It was discovered that in one of our major cities many people eat only two meals a day. When the cafeterias open at 4 P.M. they have long waiting lines for those who had not eaten at noon.

Conclusion

The main conclusion reached was the fact that there remains a tremendous area for research. We came out with more questions than when we started. For example:

Do people living alone tend to eat only two meals? If so, is this good or bad?

What is wrong with our nutrition education, that it fails to reach this age group? How can we promote, or sell, milk, fruits and vegetables, the way we have obviously sold protein?

Is one's attitude toward nutrition part and parcel of one's attitude toward life?

The area of nutrition for the elderly is a vast one, ripe for detailed research. It is a small part of the total picture of the older person and does not stand alone. For even as we work toward the education of the "whole child" we must look at the "whole grandparent."

MENTAL ASPECTS OF THE AGING PROBLEM

John Barrymore once said, "A man is not old until regrets take the place of dreams." This is another way of saying that as a person begins to grow into the later years of life the mental problems become interwoven with the physical problems in a somewhat complicated manner.

As people grow older the brain also wears out and tires. Our intelligence, our ability to manipulate our hands to perform work or to play, and our ability to control our emotions are dependent upon the nervous system of the body which is in turn controlled by the brain. As the brain slows down so do the other functions of the body slow down. For instance: reflex actions are not as fast in older people as they are in younger adults, and while the memory apparently remains good the capacity for learning is less than at the younger years. The elderly worker may be more accurate than the younger worker but does not usually produce as much in the same number of working hours. Older people usually do not have as much creative ability or originality as younger people.

While the younger workers might be contributing more to the advancement of science, for instance, the older men are usually elected to head professional organizations and associations. The average age of the past thirty presidents of the United States is 55.9 years.

While older people display more emotional upsets as a group, emotional responses are much more common among the younger aged men. Older people tend to be less outgoing and keep their problems more to themselves. They are very much aware of group approval and disapproval, and their standards of conduct are more rigid. There is a marked decrease in the feeling of satisfaction with health, and a decrease in feelings of happiness, usefulness and interest in life.

Therefore, it stands to reason that we must not wait until people are old before planning for them, but we should instead be promoting an educational program to prepare them – and us – ahead of time. *The problem is not one of prolonging old age, but delaying it.*

The emotional needs of old people are not any different from those of younger people except in quantity. They still feel the same needs for love and affection, importance, usefulness and security. Yet most old people are overwhelmed by their loneliness, their feeling of uselessness and their need for support. How can older people be brought to feel useful and wanted when they are not employed? Victor Hugo once said, "Forty is the old age of youth and fifty is the youth of old age." We must help ourselves prepare for this difficult youth rather than merely hoping that someone will take care of us.

SOCIAL SERVICES TO THE AGING

First and foremost it must be emphasized that we need to think of our older citizen as a person, an individual, a human being . . . not just a statistical figure.

As individuals, older people have certain basic and special needs and react to stimulation just as do younger people. They are the result of what they were born to be and what has happened to them during their lifetime. They want love, status, and an individual feeling of worth and security. Many of them *do* have problems. These individual problems grow out of the person's economic, physical, and emotional needs, but they also grow out of his social and cultural surroundings. Particularly does the way of life in which an older person finds himself contribute to or detract from his successful adjustment to the process of aging. There are times when the individual is unable to support himself or to continue to function as an independent individual. The reasons for this may be lack of money, the result of physical or mental illness, or other social factors, some of which are found not in the individual but in the community. It is then that social services should be available to him.

The nature of social services rendered should be two-fold:

1. Those directed as meeting the basic and special needs of the individual, (food, clothing, shelter, medical attention, etc).
2. Those directed towards making him happy, active, and feeling that he has maintained his sense of individual dignity and worth.

The first of these is simply a matter of enough money to eliminate fear and insecurity. This is done in many ways, such as Old Age and Survivors Insurance, Old Age Assistance programs, veterans pensions, retirement benefits, etc. Much is now being done to encourage industry to take a long forward look when setting up pension programs for employees.

It is with the second of our services that we should be primarily concerned. We should make every effort to rehabilitate our older folks and assist them to secure some form of employment that will enable them to earn part of their support and give them a feeling of self-maintenance.

Personal services directed at making it possible for the older person to remain at home where he is happy and in an environment to which he is accustomed is extremely important.

Older people are happier when they can remain in the stream of community life. They love their attachments with others and the community can make their life happier by providing activities for

them. Religious affiliations are important to older people. Any assistance that makes it possible for the older person to continue to go to church, or if he cannot go, provide a way for spiritual inspiration to be brought to him in his own home, is beneficial.

Older people are provided counseling services directed at strengthening their own inner resources. This includes those services which help him make use of community organizations. Services directed at interpreting his needs to relatives and friends. Services directed at strengthening family ties. Services that help the individual look objectively and constructively at his own problems. These are the social services which must be available if the individual is to be helped to live happily and constructively to the end of his days.

But how effective can these individual services be in an unfriendly social climite? What does it do to the morale and self - respect of a person, either young or old, who is made to feel that the need for financial assistance is synonomous with being a beggar, a ne'er-do-well, a failure? Can the community accept that an individual can be an adequate person and still be in need of help? Does the fact that a person is needy set him apart from his fellow man?

What happens to the self-respect and feeling of worth of the ill person who goes into the county hospital or clinic for medical care and must sit in dark dirty surroundings waiting for hours before his physical needs can be taken care of? In some places to be told at the end of the day to go home and come back the next day – and wait some more?

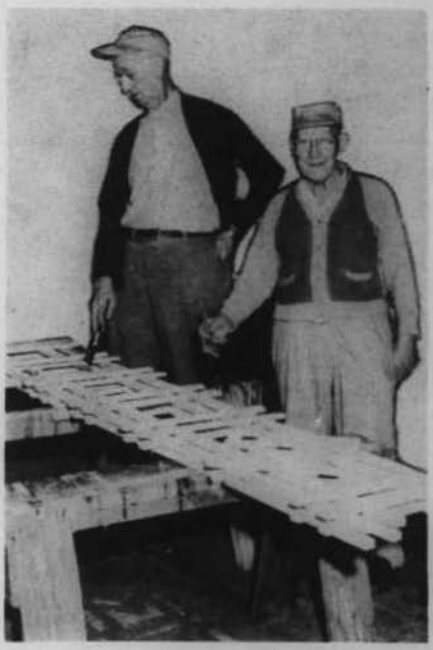
What happens to the individual whose money is disappearing and who knows that the threat of dependence and unemployment carries with it loss of status, loss of dignity, and in some instances, loss of the right to plan his own future?

It must be recognized and accepted that social services in a community must be directed not only at meeting the needs of the individual but toward developing an awareness of the problems that face the older person, his needs, and the resources and understanding that must be developed if these needs are to be met. The social worker can help the older person to try to find a job but the community must recognize that there is worth in the older person, that in the older person there is an economic resource which the country as a whole is failing to recognize. Social agencies, such as family welfare agencies, district welfare boards and the like can provide many services for older people but the community must develop an attitude which makes it possible for older people to accept help without feeling humiliated or ashamed.

VOCATIONAL REHABILITATION SERVICES OF THE STATE DEPARTMENT OF EDUCATION

Through its Vocational Rehabilitation Division the State Department of Education has been able to place over 17,000 disabled persons in suitable jobs. This service is given to any person over 16 years of age who is handicapped in getting or holding a job because of disability. The disabled person is given medical diagnosis and treatment, artificial limbs, braces, hearing aids or other physical aids needed to hold employment, training for the job, financial assistance while he is preparing for the job, and tools, books and supplies needed to help him carry out his vocational rehabilitation plan. When he is ready to go to work the Vocational Rehabilitation Service helps him find a job and to get adjusted to the work . . . It must be remembered that the Vocational Rehabilitation Service is set up to deal with the handicapped and the law does not give age as a measure of eligibility.

Aged people have two strikes against them. First, their advanceing years bring illnesses and disabilities which sometimes make it difficult to perform useful work. Second, only a limited number of employers are willing to hire older people.



In 1956 the Vocational Rehabilitation Service gave attention to the problems of approximately 6,000 persons. Of this group, 1,854 were successfully given employment. Aproximately 3,600 persons were in the process of rehabilitation at the end of the year.

Vocational Rehabilitation Service is not available to just the aging, but also includes anyone with disabilities which make it difficult for

him to obtain work. Therefore, of the 1,854 persons successfully served, 898 were over 40 years of age; 410 were above 50 years of age, and 94 were above 60 years of age. The oldest person rehabilitated was 78 years old.

Of the 94 who were over age 60 (the group about whom we're talking here) the origin of disability in 68 of the cases was disease; employment accidents had disabled 7 of them; and 19 others had been disabled because of other accidents such as automobile wrecks, falls, etc. Only 26 of them were working at the time they applied for assistance and were earning an average of $17.50 per week. Of the rest of the group 56 received their support from families, insurance, savings, etc., while 12 cases were being taken care of by welfare agencies. After rehabilitation the earnings of the 26 who were working at the time they received assistance was increased to an average of $29.70 per week. The average wage of these 94 persons per week was $36.75 after rehabilitation services.

On a basis of experience, it is believed that many of our older citizens can be made employable through vocational rehabilitation services. These services, of course, must be based on the individual needs and capacities of each person served, and selection must be made after a careful individual study. At present, many handicapped persons of advanced age are being referred to the Vocational Rehabilitation Service, particularly by the Bureau of Old Age and Survivors Insurance. Many of these appear to be primarily interested in collecting their insurance retirement benefits. Only a few of them make any effort of their own to be rehabilitated.

With the present attitude toward the employment of older people, it is difficult to find jobs regardless of the preparation of the person. Success is being achieved, however, in enough cases to warrant more attention to the problem and to the possibilities of rehabilitation. Much remains to be done in the development of public attitudes and the willingness of employers to utilize the services of older people.

THE OLDER WORKER IN FLORIDA

In Florida the older worker finds himself facing the same artificial age barriers that exist in the rest of the nation. Most employers specify "under forty" when seeking workers. Many older people obtain work in the hotel and restaurant business, in the citrus groves and in agriculture but all too often they slip easily into jobs usually associated with older workers – watchmen, guards, baby sitters, etc.

A wealth of talent lies within this group and it is unfortunate that it is not being used. Too few financial institutions, large manufacturers, insurance or real estate firms hire older people in professional, clerical, sales, managerial or technical capacities.

In a city such as St. Petersburg, the local employment office (whose active files shows 65 per cent of its applicants are over age 45) can fill almost any request for professional and technical skills – provided the employer will accept older persons. These skilled workers are financially squeezed between fixed incomes and the rising cost of living. It is ironic that clever hands and able minds of older people are so needed, yet are thwarted in their search for employment.

Examination of our manpower needs for ten years ahead shows that the only way we can find the ten million additional workers our high level economy will require is to utilize older workers fully.

Of the four "excuses" employers offer for not hiring older workers, none are true today:

1. *The older worker is not slow and can meet production schedules.* Careful analysis of production records shows no significant decline by age group, and that there is wide variation in individual output in all age groups.

2. *Older workers do not lack skills or flexibility.* Thorough evaluation of their characteristics shows them to have twice the proportion of skill as younger workers. They show considerable flexibility in accepting change in industry, occupation and earnings.

3 *Older workers can meet the physical demands of their jobs.* Only 16 per cent of jobs require great strength. Mechanization and job design can

adapt work to suit older workers.

4. *Hiring older workers does not necessarily increase pension and insurance costs.* Under the pension-and-insurance plans most prevalent today there is no significant increase in costs for new "hires" of older workers.

The role assigned the Florida State Employment Service is a challenging one offering great opportunity for public service. This is the program proposed by the Florida State Employment Service:

1. Educate Employment Service staff, employers and the public to accept and hire qualified older workers.

2. Cultivate the type of industry, for Florida, that will hire and utilize older workers.

3. Provide individual and group counseling to help older workers accept changes and adjust to healthy attitudes toward reality.

4. Launch intensive job development and promotion for qualified older workers.

5. Urge employers to adopt job analysis and job redesign techniques to assist in utilizing qualified older workers.

6. Sponsor community forums, round tables, and employer clinics as "show cases" to help qualified older workers market their services.

Let no one say Florida's older people merely had "left-over life to kill." Rather, that Florida's magic name and fame is true. "A new generation has been added onto man's life enabling him to achieve dreams beyond previous imagining."

RELIGIOUS PROBLEMS OF THE AGING

It might seem strange that a problem dealing with a religious matter should be included in a publication such as this. Yet on closer scrutiny, it is not so strange, for religion as an experience of man is universal. It is one of man's oldest and most general of all experiences. As a fact, in the life of the human person it brings influence to bear on personality, on physical and mental health and on the relationship of the individual to the community in which he lives.

This latter fact becomes apparent when in the interests of public health we turn our attention to our older citizens. One finds rather often evidence of tension, frustration and loneliness, and here and there an instance where the aged person is the center of a domestic storm. The facts often point to a religious problem.

There are the problems of changing ideas in a changing age. Religious ideas are inclined to be firmly anchored. A man who has been led to accept changes in means of communication and transportation, who may, perhaps, have moved without strain from the business methods of the country store to those of a modern super-market, may rebel with deep feeling against any change in those religious ideas. Yet he is surrounded by them. They tumble out in conversation around the family dinner table and they crop up in sermons preached by younger ministers.

Coupled with this change in religious ideas, is the problem of changing ethical patterns and values. Probably every family knows something of the hurt look in grandmother's eyes when adolescent Mary modeled her one piece bathing suit. For grandmother anything that didn't reach to the knees and include long black stockings was positively indecent. We may laugh at grandmother but we should not overlook the fact that she is hurt. Coupled with this change in ethical patterns is the

ever changing picture in values. The older person just cannot understand why the junior boy in the family is not content to spend the entire evening at home reading Dickens or Scott.

Then there is the problem that grows out of aged persons' unwillingness to surrender positions of leadership within the life of the church with resultant frustration and tension when such surrender is demanded. Pathetic indeed is the picture of the older person striving earnestly to maintain a position of leadership and influence in the congregation when younger men are gradually moving into positions of responsibility. The problem becomes even more acute when the desire for responsibility in the church is in part an effort to compensate for leadership and responsibility already denied them in the business or professional world because of age.

There is also a tendency on the part of the aged, to idealize the past and a determination that the patterns of yesterday in the church shall be retained. Many a successful man of mature years, thoroughly progressive in business methods and practice, will be insistent that his church adhere to the ideas and patterns of activity of that man's youth with all its happy memories of church life. When the church insists in moving with the times there is resultant tension and sometimes even pain both deep and poignant.

The problems that I have mentioned are all brought into greater focus by the change in today's special structure. The grandparents of today's older citizens probably lived an entire life in one place and died in their own homes. Such is becoming increasingly rare now-a-days. People are on the move and this applies to older people also. The expense of maintaining the old home place is too much for the great majority of people. This moving of population lifts the individual bodily and plants him in a new situation where he may be confronted with new ideas and religious practices and where the problem of transportation may be serious. To this, youth and even middle life can adjust, but not the aged with but few exceptions.

Here is an area where medicine and religion can join hands and make a real contribution to the well being of an ever increasing part of our people.

Our churches must recognize the senior citizen as a person with very real claims on the religious community. Plans should be carefully developed for recreation and adequate provision made to meet the social needs of such people. The professional training of the minister should include courses in the psychology of the aged and how to counsel such persons.

RESEARCH INTO AGING

The research studies now being done on aging can be roughly classified into four broad categories: medical, social, economic and emotional or psychologic.

Intensive medical studies are going on in many fields which are related at least in part, to the specific problems of age and aging. While the studies of various heart diseases are dedicated to improving the health of the younger group, the progress being made is of definite interest to the aged. This is also true of the work being done on high blood pressure, arthritis, diabetes and cancer.

The social and economic problems of our senior citizens are also being studied. Frequently, these factors are more important in their effects on the aged than the impact of chronic disease to which most of them eventually achieve some degree of acceptance and adjustment. We live in a culture that emphasizes youth and its capacity for work and play. Our social pattern makes little provision for the needs and desires of age. We take persons who have been leading useful, busy lives and tell them they no longer need to work – all this in a society where work is associated with usefulness – and wonder why this is so hard to accept.

The word "senile" is used as a catch-all for the many conditions still not too thoroughly understood. (The dictionary says "senile" pertains to characteristics of old age).

A physician at the Geriatric Clinic at Jackson Memorial Hospital in Miami, tells the story of a patient who was labeled as senile, whom he was warned against admitting to the Clinic. After undergoing a physical examination and enjoying the attentions of a social worker, a psychologist and others, the patient became aware of the interest others took in him as an individual. He lost the characteristics of senility which he had previously exhibited and was revealed for what he was – a neglected human being.

But all the broad categories of research we have listed above in the first paragraph are but many sides of the one central problem. *We need to achieve some understanding of the whole person;* not merely to call a man a "heart case" or an arthritic, or senile or in his second childhood. He may be any one or all of these things – but he still has other problems and other sides to his personality.

In Dade County a research project has been started to investigate the reasons why individuals are confined in nursing homes, convalescent homes, old-age homes, and other similar places at county expense. We hope to learn why some people end their days in such institutions. What combinations of medical-economic-social-and-emotional factors lead people to live in such homes? What are the underlying factors which lead families to place elderly individuals in such institutions after years of taking care of them in their own homes? What types of disease may lead individuals into such surroundings? Could some or all of these diseases have been prevented? Could these people be rehabilitated for life outside of institutions, or at least to a better enjoyment of the years remaining to them within these facilities?

We have accumulated a large number of "whys" in this work, to which we have learned only a few answers.

We know that medical disease is not the primary difficulty; that social, economic and emotional factors are of greater importance. Perhaps the main issue is to make the elderly understand that they still have a place in life. That they are not being put away to die. That they are still wanted and needed in society; that they have a place in the sun and a useful function to perform. That they are needed now as much as in their youth, but in a different way.

Through research we will achieve an understanding of the problems of old age. But the *results* of this work must be applied through the heart and soul of man.

COMMUNITY RESPONSIBILITIES TO THE AGING

Although communities have many responsibilities to their aging people, these can be resolved into four basic approaches:

1. Community action must be locally inspired and carried out.

It is the duty of the able citizens of the community to work out their problems and search for a solution that will solve them in the most economical way. Thus far the task of encouraging communities to get busy on the problems of their old folks has been rather difficult.

2. Communities must devise ways to make it possible for older people to help themselves.

The financial aid needed to support the aging can be a big burden for the community and if ways to afford work for these oldsters can be worked out, the community profits. National studies show that most old people cannot live off their savings or accumulations of property alone. Too, an older person producing at a reduced rate is still earning a part of his support and helping to maintain himself.

3. Communities must regard their efforts to help the older person as investments rather than added expense.

Recent studies show that it is

very rare for older persons, regularly visiting New York City Day Centers, to be hospitalized for mental illness. In 1952 the cost to the taxpayers of caring for one mental patient was $1,095.31 a year, of which $323.66 was for maintenance and $771.65 for care and service. Since the average stay in a mental hospital was estimated by Dr. Howard Rusk at eight years, the approximate cost would be over $8500. The cost of care and services for each Day Center member is only $30 per year; therefore, taxpayers have a monetary as well as a humanitarian stake in helping solve the problems of older persons.

4. The community must help rehabilitate older people wherever possible. Putting the older person back into a useful place in community life raises his morale and gives him a feeling of belonging. He is able to provide for a part of his support, thereby relieving the citizens of a portion of the tax burden involved. Older people develop new interests and thus further relieve the tax burden by not becoming mental patients. And the fact that they again feel somewhat independent keeps them out of the institutions supported by tax money.

But what can a community do about their older people? Here are a few suggestions:

1. Form a Speaker's Bureau to help develop awareness and interest in the problems of aging.
2. Examine the problems of older people in your own community.
3. Urge local employers to retain older workers in jobs matched to their individual capacities even if it involves some downgrading.
4. Investigate the advantages of rehabilitation – for a vocation, if possible; if not, then for physical self-care.
5. Encourage elderly people to become active as volunteers in community activities and enterprises.
6. Establish Day Centers or Senior Centers. Senior Center at Jacksonville (sponsored jointly by the Pilot Club and the Salvation Army) is an example of a sit-down social center doing a worthwhile job.
7. Encourage adult education classes at all levels necessary to enable older people to pursue a large number of vocational and intellectual interests.
8. Encourage local builders to provide more suitable housing for older people.

The question which troubles most older persons as they see retirement approaching is how to maintain a decent, independent, American standard of living on a sharply reduced income. Because pensions and savings usually add up to only a meager monthly income, older people worry about imposing on hard-pressed children for financial support.

Dependency, work and deterioration thus become the destiny of many aging persons who have contributed a lifetime of productive activity to the amazing growth of the American economy.

The States and Their Older Citizens . . . . .
The Council of State Governments

There are compelling reasons why older people should continue to work as long as they are willing and able. First, they want to. Second, the cost of supporting millions of older people for years in retirement is prohibitive. Third, the productive capacity of older people is required to maintain our high standard of living.

"No Time To Grow Old"
by the New York State Joint Committee
on Problems of the Aging

"The old adage 'you can't teach an old dog new tricks' is fallacious, and is doing a great deal of social harm. You can teach an old dog new tricks if the dogs have incentive to learn, if the teacher knows more than the dogs, and if the teacher knows how to teach."

Thomas C. Desmond,
State Senator, New York State
Chm. Joint Committee on Problems
of the Aging

"This matter of aging has been approached with a good deal of ambivalence. At the outset the increase in the number of older people and the extension of life expectancy were a cause of grave anxiety. True, we developed a number of superficial cliches like "growing old gracefully" and "the best is yet to be." But essentially the picture presented was that of a growing number of socially isolated, financially dependent old people subject to prolonged illness and mental and physical deterioration.

More recently, a new concept has been gaining acceptance. We are beginning to see that, instead of prolonging the period of dependency and dying, what we are really doing is adding a whole new period to the life cycle and creating a new generation in society, whose true potential we have only begun to explore."

Clark Tibbitts
Sixth Annual Southern
Conference on Gerontology
University of Florida, 1956

"The community, the neighborhood, the home town—here lies the key to the problem. Only in the home town can the final job be done. No national conference, no Federal Agency, no transcontinental educational campaign can take the place of neighbors helping one another in their own community."

Oscar R. Ewing
Former Federal Security Administrator
"Man and His Years"

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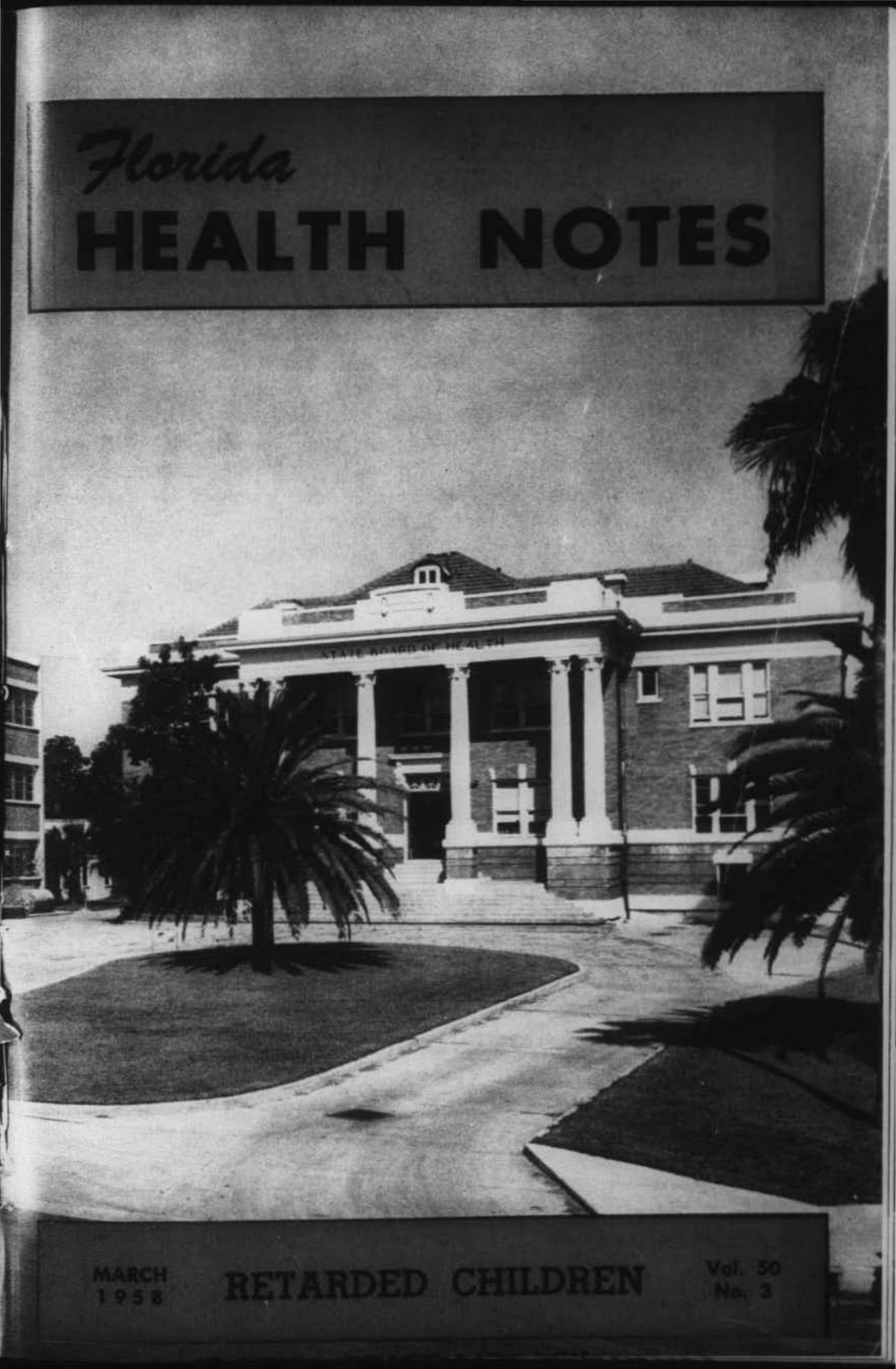
Florida HEALTH NOTES



MARCH 1958

Vol. 50 No. 3

RETARDED CHILDREN

God's Children

We call them retarded because they are slow
Unfortunate, too? – A thousand times, "No".

Is it so tragic to live out one's life
Free from the worry of struggle and strife?
Free from the gnawings of envy and greed,
Free from desire to fill every need.

To show the world we're so big and so smart,
To spend all our time, just playing a part
For which, perhaps, we're not even fitted
But to which, by some fate, we've been so committed?

A dignity's theirs the rest of us lack,
They have no need to slap on the back
Another from whom they seek favor or things.
Their trust's in the One from whom all favor springs.

To be sure, with not one would we want to change places;
And yet, just a glance at their sweet happy faces
Should prove beyond doubt that they really know
They are God's Children – the retarded and slow.

– Marjorie McMaster

RETARDED CHILDREN

In every city, town and village in Florida there are children who are mentally retarded. They may be called by many other names (sometimes by thoughtless, unkind people): morons, imbeciles, stupid, backward, slow. But the fact is that they have been retarded – held back. For the phrase "mentally retarded" does not describe a disease but a *condition*. Perhaps the simplest way to describe it is that although the other parts of the body may grow normally, the brain may not develop at a normal rate.

In the Sunland Training Center, formerly the Florida Farm Colony at Gainesville, there are 1400 of these children, of all ages, but there is a waiting list of 800. It takes about 18 months on the average, for a child to be admitted, *after* the parents have made proper application, *and* if he has been accepted.

Public health nurses in Florida's 66 County Health Departments try to help anxious parents during this waiting period to become accustomed to the idea of sending their child away for education and training – if he is teachable. Often their work begins even farther back, in helping the parents to see *why* their child may have to be placed in an institution. Or if he is not severely retarded, how they can help him become adjusted to living with persons with normal mental development.

Until only a few years ago parents of mentally retarded children were victims of superstitions, fears and taboos. There was a widespread belief that mental retardation was almost entirely hereditary – passed on from one generation to another. Parents of these children were looked on askance

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FLORIDA HEALTH NOTES

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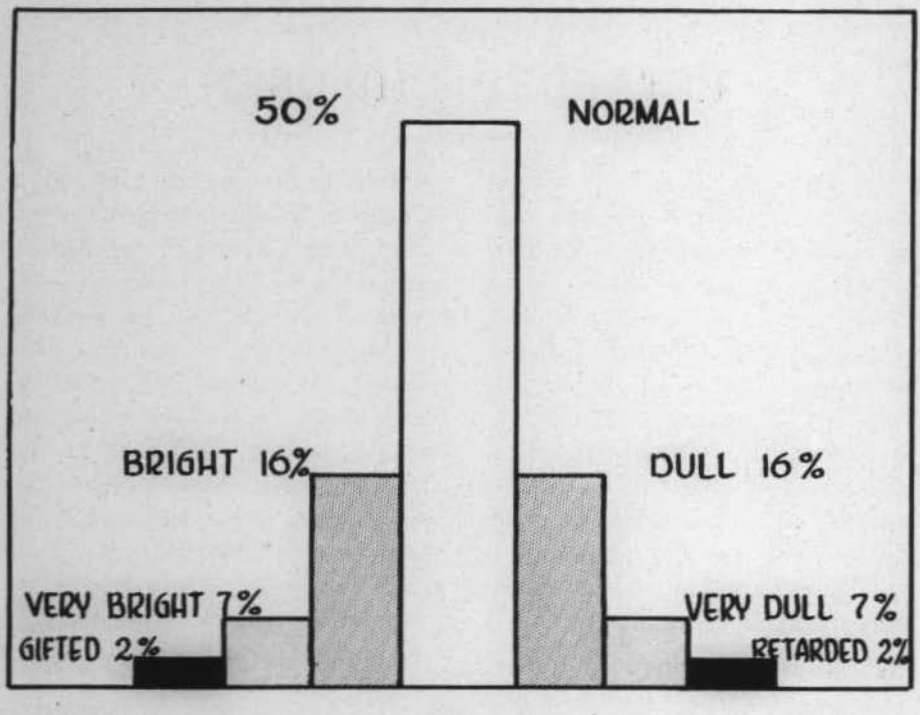

This chart shows the percentages of Florida children who are bright as compared with those who are retarded.

and neighbors whispered behind their backs. The brothers and sisters of a retarded child were shunned by others in the neighborhood. The physical, mental and financial strain on the family of a retarded child was a heavy burden and so parents were inclined to shut the child away from the world and draw into a shell to avoid the embarrassment of facing others.

Some parents believed that if they brought a child into the world who was mentally retarded that this was punishment for real or imagined sins they had previously committed. To these parents, the sight of their child was a constant reproach, and this did not help the situation.

But researchers in the medical profession were concerned over the problem of the retarded child. Lack of financial support made it difficult to devote much time to the study of this condition. For a long

time nothing much was known of the cause and effect of various factors before birth, during birth, and after the child was born that we know today cause many retarded conditions. Without knowledge it was virtually impossible to overcome the superstitions and fears of generations. Little, if any, legislative support was given to this problem. The public did not want to become involved in this delicate situation. It was too heart-rending, too difficult to understand.

But doctors, psychologists, nurses, laboratory researchers and a host of others still went about trying to solve this problem of retardation and trying to bring knowledge instead of fear to the families of these children. And a lot of progress was made.

What Causes Retardation?

This was, of course, the first question to which the researchers wanted to know the answer. Case studies began to stack up as records were carefully kept in doctors' offices, hospitals, clinics, and institutions throughout the nation. After many retarded children were examined there seemed to be certain factors present in specific cases where the children examined all had the same condition. This was a lead to the researchers who then followed up on the factors to see if they were a *cause* of the trouble or an *effect*. For instance, hereditary retardation, which had long been thought to be the source of *all* retardation was now shown to be the cause in only about three per cent of all retarded children. They further learned that this sometimes happened when they came from the union of parents who were themselves not too bright.

But scientists also learned that somewhere along the line prior to the birth of the child, regardless of the mental ability of the parents, something occasionally happened to the genes to change the child from normal to abnormal. The genes pass on the characteristics of the parents to the children, such as the color of the eyes, shape of the face, size and build, intelligence, and other factors which make children resemble their parents. These genes, while not destroyed, were in some way changed so that they caused the child to be born with an abnormal condition. It might be a blood or circulatory disorder that resulted, or a gland, (or glands) that were functioning too much or not enough, resulting in injury to the brain. An example of this latter disorder is cretinism, which results from a deficiency of the thyroid gland.

Psychologists use varied tests to establish the mental age of a child.

Sometimes the mother contracts a disease such as german measles, whooping cough or polio while she is carrying her unborn child. Since some germs can penetrate living tissue, they may enter the body of the unborn baby and attack the brain tissues. Sometimes the child is then born blind or deaf or shows signs of being mentally retarded very soon after birth. In some instances, two or more of these deficiencies may show up in the same child.

Sometimes damage to the genes may cause different results in different children. For instance, in some cases the head does not grow after birth and remains small throughout life while the rest of the body continues to grow and develop normally. This compression of the brain into a smaller space than it should normally occupy results in retardation. (Children who have this condition are called microcephalics). At the other extreme a blockage within the brain

may prevent the normal flow of fluids (generated in the spinal canal) around the brain and back down through the spinal canal. The head fills with this fluid and cannot dispose of it normally so an enlarged condition results wherein the brain gradually deteriorates because of the fluid condition. (This is called "water-on-the-brain" and these children are known as hydrocephalics).

Another cause of mental retardation results from injuries at the time of the child's birth. The mother may experience difficulty in labor or the child may be a breech birth. Perhaps, due to some unusual condition at the time of birth, the oxygen supply to the baby is somehow interrupted or cut off. This will sometimes cause mental retardation.

Children retarded because of injuries or accidents at birth often are epileptics, victims of cerebral palsy, or have one or more limbs paralyzed. Difficulty of speech is quite common with this group and convulsions may also occur.

Obstetricians recognize that their problem is one of careful prenatal care of the mother. Advances in maternal care will make for less mental retardation, as well as other troubles among the newborn.

After a child begins its life, disease and injury account for a small number of retarded children. Encephalitis, an infection of the brain tissues, can cause trouble. Sometimes the childhood diseases such as german measles, whooping cough and chicken pox attack the brain cells. Meningitis accounts for many cases. Accidents that in-

jure the brain and even the accidental taking of poison sometimes destroys the brain tissue and cells and the child becomes retarded.

What Hope Is There for The Retarded Child?

Although mental retardation has been studied and broken down into more than a hundred different types of deficiencies, much more is to be learned before retardation, as such, can be substantially reduced. But great strides have been made and the unsung heroes of the battle are the doctors in the office, clinic and hospital, the nurses and attendants who give tender, loving care, the laboratory scientists with their test tubes and microscopes, and certainly the parents of the children themselves who have formed associations and other active groups to promote research and study.

From all this combined effort have come drugs and treatment that now make it possible for some of the retarded children to learn to care for themselves, to dress themselves and handle their eating utensils properly. Some can even acquire some degree of skill in operating printing equipment, woodworking tools, cooking, sewing and other homemaking duties. Some are finally entered in the first grade of school and many move forward to the higher grades.

Sedatives and tranquilizers are

now used in mental retardation to relieve emotional upset and also to reduce the severity of the condition. Doctors at the Sunland Training Center, the state institution for retarded children at Gainesville, have hopes that they may be on the track to relieving the condition known as hydrocephalus, or water-on-the-brain. They hope to see the day when they can prescribe drugs for a brain that has failed to grow normally which will start it back on the path to normal full growth.

One of the brightest pictures thus far concerns mongolism — which accounts for 22 per cent of the children at Sunland. Research has brought to light the fact that an expectant mother might be subjected to some unusual condition that retards her circulation during the first six to ten weeks of pregnancy. Perhaps she takes a long trip, makes an air trip, is confined to her bed for a couple of weeks due to illness, or in some other way impairs the normal circulation. In some cases this has resulted in the child being born a mongoloid. Doctors can now detect the potential mongolism through tests made of the thyroid and other endocrine glandular functions. Through early treatment of these deficiencies they note the possibility of bearing a mongoloid child is greatly reduced. And after the mongoloid child is born doctors can now prescribe drugs aimed at overcoming the condition to the extent that retardation is not likely to occur.

Further study has shown that if the mother's body does not properly use the amino acids normally found in the daily meals, the unborn child might be retarded. Therefore, when tests made on the mother indicate that her body is not properly using the amino acids, her diet is adjusted to eliminate them and prevent the possibility of retardation from that cause.

Gains have been made in treatment for some of the other types of mental deficiencies also. Dwarfism and giganticism, which result from pituitary upsets, gargoylism, galactosemia, and tuberous sclerosis are all showing positive response to treatments evolved within the last few years. (We won't attempt to describe these conditions here).

Medications now available indicate that it might be possible soon to control convulsions in epileptics — and since each convulsion has a damaging effect on the brain, elimination of convulsions will also eliminate further retardation from this cause.

But what of the little brain that has been physically damaged by injury or disease? The doctors say they cannot see too much hope for learning how to rebuild brain tissue in the near future, although they will never stop looking for ways to do so. The best way to eliminate

retardation from these causes is to do everything possible to prevent injury and disease.

The bright part of the picture is that almost every retarded child, given proper attention by trained personnel will respond in some way and show improvement.

What Are We Doing About It Today?

In the past few years the Florida legislature has passed much favorable legislation to expand the facilities for the care of these children. Bills pertaining to the support of these institutions as well as legal statutes to make the job easier have been introduced. State funds are now being used to provide more and better care.

The general public is waking up to the need for more treatment and training centers. More communities are giving thought to the problem of their retarded children. Citizens should take a long look at their own home town and the facilities available for these children.

With proper support the state institutions, such as Sunland Training Center, have been able to expand housing and treatment facilities. A new center, known as Sunland Training Center at Fort Myers is now in the planning stage. As we said at the beginning, Sunland Training Center at Gainesville has 1400 children enrolled for care and treatment with a waiting list of 800. With the present limited facilities it takes 19 to 24 months for a child to be admitted after the parents have made the proper application. Expansion is planned to increase their present housing to include another 600 children but it still will not meet the need.

Chapel — Sunland Training Center

Florida's County Health Departments are working to provide public health nursing and prenatal care to expectant mothers who cannot afford private medical care. Through this valuable service many of the cases of retardation that may have resulted from lack of attention to the mother or baby, may be avoided.

The parents of the children themselves have banded together. The National Association for Re-

Children are housed in modern brick cottages at Sunland Training Center. This cottage is occupied by thirty boys.

tarded Children has chapters in most of Florida's larger cities and towns. Funds are raised and used to promote better ways of treatment, as well as research programs. In some communities local schools and training centers have been established and many children are receiving help from these first steps in the right direction.

It Used To Be .....

In 1919 the old Florida Farm Colony was established on 3,000 acres of land donated by the citizens of Alachua County. Construction was started and by 1921 three buildings with a capacity of 160 patients were finished. The first patients were received on November 1, 1921. By 1923, 242 patients had been admitted, including 53 children who were transferred from the Florida State Hospital at Chattahoochee. Since 1921, over 3,000 children have passed through the gates of this institution.

The Farm Colony continued to grow slowly. By 1930 the population was 455. By the end of 1947 the first floor of the hospital had been completed. In the past ten years more than six million dollars have gone into new buildings and

IF YOU HAVE A RETARDED CHILD OR W
THE FOLLOWING NAMES AND ADD

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Dr. John Browning
614 South 11th Street
Ft. Pierce, Florida

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North Florida Association for Retarded Children
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5429 Altha Street
Jacksonville, Florida

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Hillsborough Associaiton for Retarded Children
Mrs. J. Clifford McDonald, President
Route 2, Box 54
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Unit 3

Escambia County Association for Help to Retarded Children
P. O. Box 441
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Mr. Eddie Bonifay, Prtsident
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Pensacola, Florida

Unit 4

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1240 E. Parker Street
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Unit 5

Central Florida Association for Retarded Children
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Orlando, Florida
Mr. William Hudson, President
4604 S. Ferncreek Avenue
Orlando, Florida

Unit 6

Sarasota - Manatee Association for Retarded Children
Mrs. Norman Christensen, President
3302 2nd Avenue W.
Bradenton, Florida

Unit 7

Ridge Area Association for Retarded Children
P. O. Box 731
Avon Park, Florida
Mr. G. F. Ward, President
P. O. Box 177
Avon Park, Florida

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R RETARDED CHILDREN

sociation for Retarded Children

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c/o McDonald Training Center
Tampa, Florida

Unit 8

Martin County Association for Retarded Children
Bin 7, Stuart, Florida
Mr. Ronnie C. Cross, President
533 Madison Street
Stuart, Florida

Unit 9

Okaloosa Association for Retarded Children
Mr. Walter W. Lindberg, President
31 Park Drive
Fort Walton Beach, Florida

Unit 10

Retarded Children's Society of Dade County
Room 309 Professional Building
Miami, Florida
Mrs. Hannah Kahn, President
40 N. E. 69th Street
Miami, Florida

Unit 11

Brevard County Association for Retarded Children, Inc.
Box 426, Cocoa, Florida
Mr. Karl Hunziker, President
1311 Hardee Circle
Rockledge, Florida

Unit 12

Maysland Parent's Association for Retarded Children
Mr. Julian R. Henry, President
703 E. 37th Street
Hialeah, Florida

Unit 13

Pinellas Association for Retarded Childrtn
Mrs. Paul F. Wallace, President
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St. Petersburg, Florida

Unit 14

Lee County Association for Retarded Children
P. O. Box 1592
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Mrs. Richard C. Brannen, President
2957 Cocoa Avenue
Ft. Myers, Florida

Unit 15

St. Lucie Association for Retarded Children
Dr. John D. Browning, President
614 South 11th Street
Fort Pierce, Florida

construction. In 1957 the legislature changed the name from Farm Colony to Sunland Training Center. The present program of expansion is aimed at providing facilities for 2,000 children.

This is quite a change, since the records show that as late as 1950 the center had neither a full-time doctor nor a full-time dentist. Then

Busy hands – good therapy

there was only one registered nurse, two teachers and a part-time psychologist from the University of Florida. Now there are three full-time doctors and a position in the budget for a fourth one. There are two dentists, eleven registered nurses and two supervisors, a director of training, a school principal, nineteen teachers, four registered occupational therapists and three therapists' aides. There are two directors of recreation and a director of the psychology department who has four psychologists to assist him. There are three social service workers. The Vocational Rehabilitation Service of the State Department of Education has a director and three counselors who place children in jobs on the outside whenever possible. About five per cent of the population may eventually work outside. A new chapel has been completed and there is a budgeted position for a chaplain.

The growth and expansion of the Sunland Center is a good indication of the growing awareness of the public to the big problem of mental retardation. In addition, it has already been mentioned that the Sunland Training Center of Fort Myers is now under construction and is being prepared for a population of 800 children.

There are some outstanding private centers in Florida and some which are maintained by the city and county school systems. There is not room here to list them but anyone desiring this information may get it by contacting the State Department of Public Welfare, P. O. Box 989, Jacksonville, Florida, or by writing for a report by the Committee on Residential Schools and Private Homes of the Florida Council for Retarded Children. This report may be obtained from Mrs. B. F. Cronkite, 1240 East Parker Street, Lakeland, Florida.

Portion of the occupational therapy room at Sunland Training Center. Children are taught weaving, printing, metal tapping and many other skills.

Many Can Learn

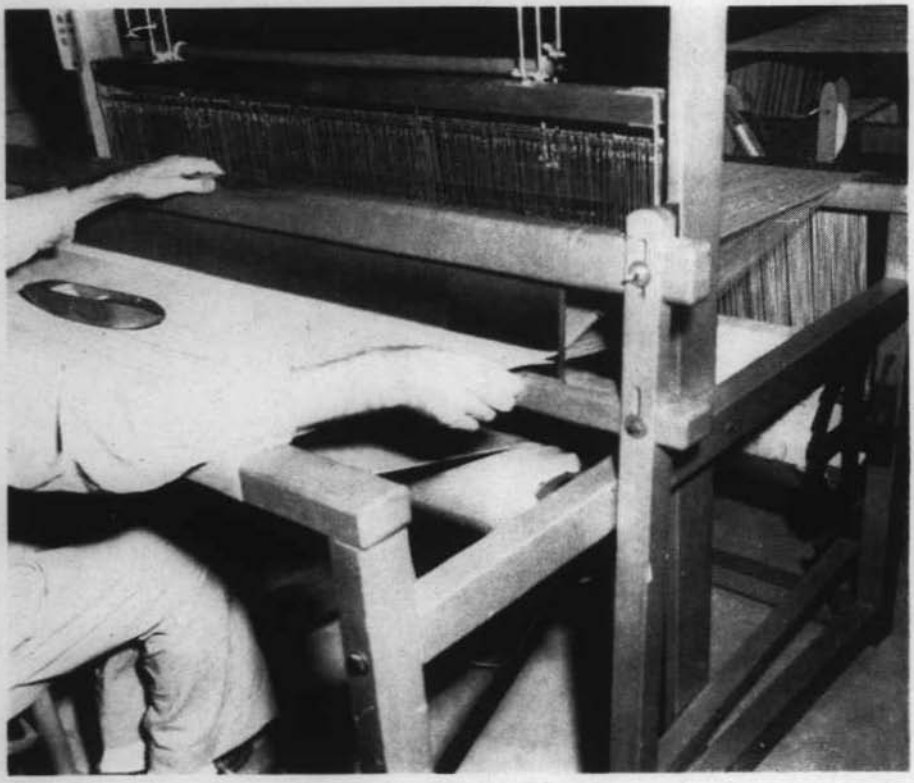
The training and rehabilitation given retarded children in either public or private schools is, of necessity, based on the ability of the child and the degree of retardation. Generally, the children are placed in three groups – educable, trainable and severely retarded.

The educable group represents the highest level and are usually "borderline" cases. The educable child is able to learn some academic skills, such as reading, writing and arithmetic. He can probably learn to the level of the fourth grade by the time he reaches his mental maturity. He can learn to work in the outside world and in most instances become self-supporting when he becomes an adult. His rate of mental development is from one-half to three-fourths that of the normal child. Although his vocabulary will be limited, his speech and language will serve him adequately in most circumstances. He can usually learn to get along with other people.

The term "trainable" is used to differentiate between the "edu-

able" retarded child who can learn some academic skills in school, and the more retarded child who cannot. However, the trainable group do have some capacity for learning how to take care of themselves, and how to get along with others. They are often capable of assisting in some chores around the house or in doing routine tasks for pay in a sheltered environment and under supervision. Their speech will be distinctly limited; however, they can learn to protect themselves from common dangers. The trainable child will require care, supervision and financial help throughout his life.

The severely retarded child is the one who is unable to be trained in total self-care, socialization or economic usefulness and who needs continued help in taking care of his personal needs, such as feeding himself or going to the bathroom. A person like this requires almost complete care and complete supervision throughout his life, since he is unable to survive without help from others.



The training activities of any institution or group serving retarded children must be based on the results of research and study as to what is best for the children they serve. It is usually not wise to try to enter a retarded child in a training center until he is about six years of age. The State Department of Public Instruction has a group of trained specialists who visit the homes of retarded children under the age of six. These teachers instruct the parents in methods of simple training in preparation for the day when they might be admitted to a training center or school.

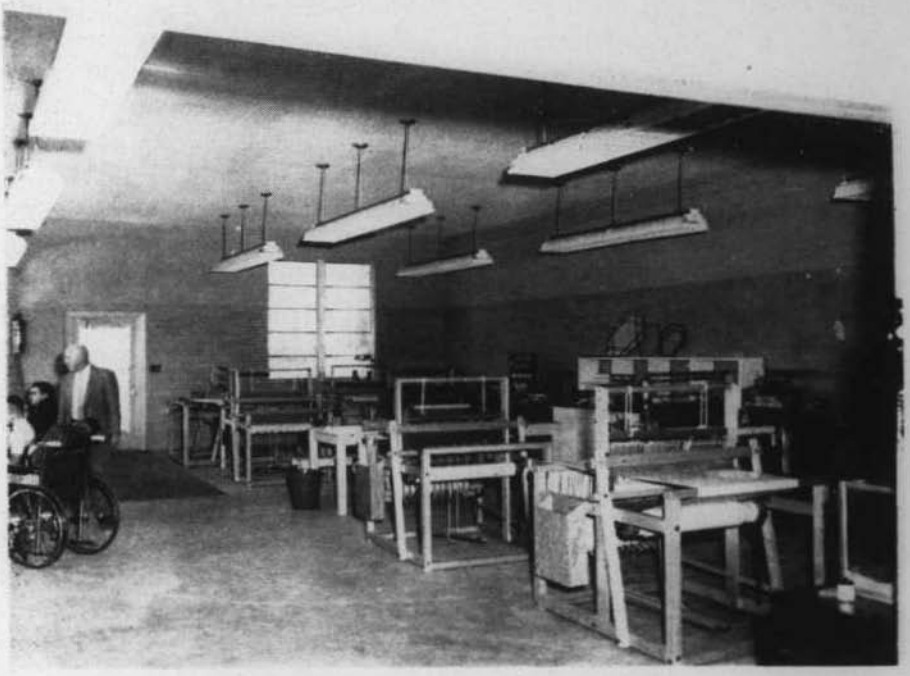
Fortunately, limited time is not an essential ingredient to successful treatment or training. Unlimited patience is the secret of success for a good occupational therapist. Hour after hour is spent with a child endeavoring to teach him simple movements of the hands and feet. In occupational therapy the child is first taught the simplest of body movements and praised highly for the slightest achievement. As time passes he will learn to thread a loom, or set a stick of type by hand, or pull the lever that makes the printing press operate to transfer the ink from type to paper. Every sheet that is printed brings encouragement and praise from the therapist.

Home Economics classroom at Sunland Training Center.

The educable group are given lessons in a classroom just like the average child attends. But here again, the time element means nothing. There are no semester periods where a child must complete a given amount of assigned work or have to repeat the semester. Here the teacher moves through the necessary studies at the pace the child's retardation permits. Even if it takes three years to complete the work that is done by the average child in one year, the teacher is elated over the results and recommends that the child be advanced to the next higher grade. Here again the long, slow process of learning subjects a little more complicated begins where the child is capable of learning.

T L C

Through it all runs an element without which nothing could be accomplished – "Tender, Loving Care" or "TLC" as it is usually described. The visitor to Sunland Training Center is impressed with the devotion shown by the children to their teachers and attendants – devotion that is just as warmly returned to the children. Without this affection for each other the work could never progress, for re-



Light, pleasant surroundings, carefully supervised work, patience, and tender loving care make this occupational therapy building a place the children of Sunland Training Center look forward to visiting.

gardless of the physical age, the mental age of the child is still just that of a child. A child who accepts his teachers, therapists, and attendants as his mother and daddy.

In a way, children in such institutions are a little more fortunate than the average child since they may have as many as twenty persons on whom to lavish their affection.

For this reason, the choice of therapists and attendants is of extreme importance. Careful training and supervision are necessary until a new attendant is successfully oriented. For work of this nature is not routine. There can be no impatience, but only that love and affection so eagerly sought after by the children.

The public can help, too. A sympathetic understanding of the situation can build trust and confidence in the parents of retarded children. By doing away with fears and superstitions, parents will be able to accept retardation for what it is – an unfortunate circumstance, a condition rather than a disease, a lack of mental growth rather than a form of insanity.

By achieving public understanding, the parents and many children will be able to live normal lives. The funds needed so badly for further study and research into the problems of retardation will be more easily procured. And more and more rehabilitated children will be able to return to their families and friends to take up a fairly normal life.

So the picture of the retarded child situation in Florida is one of optimism and hope. Research into new medicines and treatment are continuing and moving at a faster pace than for many years. More children are being returned to their homes and parents. Some are even fully or partially self-sustaining.

At present, even with increased attention and activity, Florida still needs more facilities for the care and treatment of retarded children. Our population is increasing at the rate of about five per cent per year with a resultant increase in numbers of retarded children. A long forward look should be taken and future plans made to take care of these children – and more important, to try to *prevent* mental retardation through better care of mothers and babies.

Is it any wonder then that the State Board of Health, particularly the Bureau of Maternal and Child Health, the Bureau of Mental Health, and the County Health Departments are greatly interested in these children? For our watchword has always been *prevention.*

These hands are making a pom-pom rug. Children learn skills through slow, patient instruction.

In some of the counties, public health nurses are performing pre-admission studies on children currently on the waiting list for the Sunland Training Center. Frequently work with the parents makes commitment unnecessary by the development of parental insight, increased understanding and the development of constructive activities of an enriching nature for the child. Techniques of being more effective with the brothers and sisters of the retarded are frequently outcomes of this service. With funds from the Children's Bureau the State Board of Health last year employed four full-time professional workers in certain clinics around the state to stimulate and augment increased services for retarded children and their parents, both diagnostic, treatment and community organization for program development. Again with the U. S. Children's Bureau funds the State Board of Health is participating in the organization of an intensive diagnostic and treatment center for retarded children in conjunction with the Dade County Health Department and the University of Miami Medical School. Last year the 14 child guidance and community mental health clinics saw for diagnostic and/or treatment 498 retarded children and their families. Personnel from the State Board of Health and the County Health Departments have been frequent consultants to local associations for retarded children. It is the belief that some of the mass techniques employed in public health are particularly valuable in the field of mental retardation because of the tremendous need for education, research and prevention in this very serious health problem.

THUS A CHILD LEARNS

Thus a child learns: By wiggling skills thru his fingers and toes into himself, by soaking up habits and attitudes of those around him, by pushing and pulling his own world.

Thus a child learns: More thru trial than error,
more thru pleasure than pain, more thru experience than suggestions, more thru suggestion than direction.

Thus a child learns: Thru affection, thru love, thru patience, thru understanding, thru belonging, thru doing, thru being.

Day by day the child comes to know a little bit of what *you* know, to think a little bit of what *you* think, to understand *your* understanding. That which *you* dream and believe and are, in truth, becomes the child.

As *you* perceive dully or clearly, as *you* think fussily or sharply, as *you* believe foolishly or wisely, as *you* dream drably or goldenly, as *you* are unworthy or sincere,——

Thus a child learns.

Dr. Fred Moffit
Albany, New York

(The above holds true for *all* children.)

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All Counties in Florida have organized county health departments, except St. Johns County

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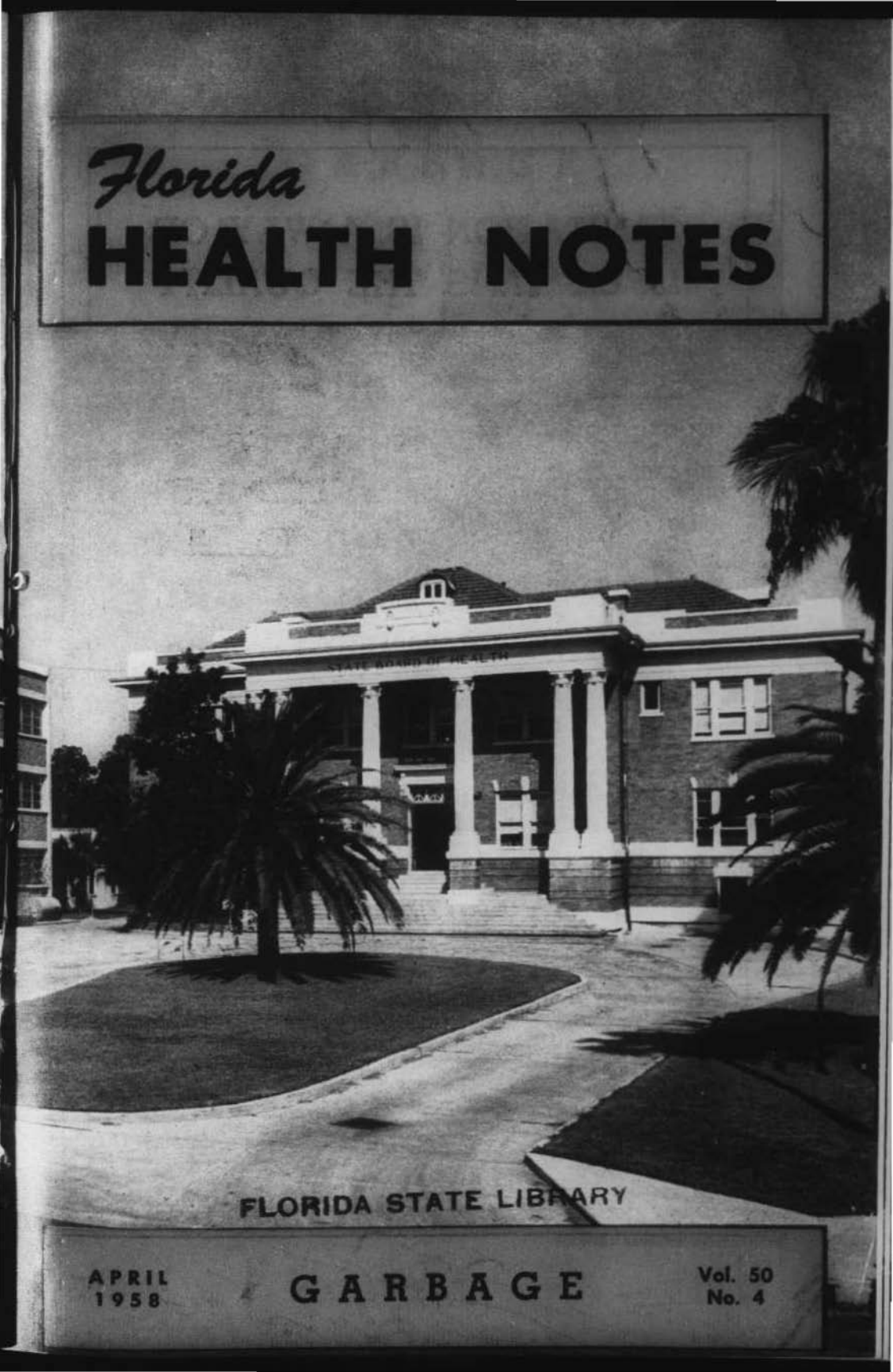
Florida HEALTH NOTES



APRIL 1958

GARBAGE

Vol. 50 No. 4

SANITATION IS A WAY OF LIFE. IT IS THE QUALITY OF LIVING THAT IS EXPRESSED IN THE CLEAN HOME, THE CLEAN FARM, THE CLEAN BUSINESS AND INDUSTRY, THE CLEAN NEIGHBORHOOD, THE CLEAN COMMUNITY. BEING A WAY OF LIFE IT MUST COME FROM WITHIN THE PEOPLE; IT IS NOURISHED BY KNOWLEDGE AND GROWS AS AN OBLIGATION AND AN IDEAL IN HUMAN RELATIONS.

—The National Sanitation Foundation

GARBAGE

The word "garbage" is loosely used to describe kitchen wastes, yard refuse, trash, and other forms of waste matter that accumulate almost daily in the average household. Left-over food, which will sour, spoil, and smell bad is the chief offender to our noses — and good sanitation. Garbage attracts flies and other insects. Rats, roaches, and all sorts of creatures are attracted to it and they sometimes bring with them disease.

For this reason, the disposal of garbage is of vital interest to the Florida State Board of Health. County Health Department sanitarians, health officers, public health nurses and specialists in the field of sanitation are carefully keeping an eye on garbage disposal systems. They also give advice — or sometimes a word of caution — to civic planning groups concerned with garbage disposal.

Florida is proud of its lovely scenery, and laws to prevent throwing trash and garbage on the highways and streets have been passed. Local beautification groups have even gone so far as to offer rewards for the arrest and conviction of violators of these laws. The State of Florida has even made available

Evidence of the pride Floridians take in the beautification of their highways is indicated in this sign — one of many seen throughout the state.

FLORIDA HEALTH NOTES

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trash cans along the most-used public highways, with large signs encouraging people to use them and not clutter up the scenery with trash and garbage carelessly thrown around.

Originally garbage wasn't much of a problem. When people lived in rural areas there was so much distance between houses that such food wastes did not bother the neighbors. Most of the table scraps or food wastes from the kitchen went into the hog troughs and to the chickens, for feed, and other wastes were piled up at a distance in the woods and burned, or put into pits.

But our cities began to grow. Subdivisions were built and houses began to be pressed closer and closer together. Garbage dumps in populated areas were not welcome since they bred vermin, bad odors and disease. So trucks were put into service to haul the garbage to outlying areas where it was then dumped. But our nation continued to grow. Soon the dumps were engulfed in housing areas and the trucks had to haul the garbage farther and farther before it could be disposed of properly. This was seen to be an inefficient method of disposing of it so incinerators were used to burn the garbage instead of hauling it to distant dumps.

Some cities grew so fast there was not even space left for incinerators. These cities must rely on barges that carry their garbage many miles out to sea where it is dumped into the ocean.

The average housewife, dumping garbage into the can doesn't even subconsciously realize that for each person in her family she is disposing of one pound of garbage and one pound of trash daily. If there are five people in the family this will amount to almost two tons over a period of a year. Multiply the two tons by the number of families in the community and it can be quickly seen that the proper disposal of such huge quantities of garbage and trash is a mountainous job. So mountainous, in fact, that no community can exist today without good garbage disposal.

Types of Disposal

There are several systems in use today. The ones most commonly used are:

OPEN DUMPS—Here the garbage and trash are dumped into a low area where it usually catches fire and is partially burned up.

INCINERATORS — Where the garbage is trucked to a centrally located incinerator, burned and reduced to about 25 per cent of its original volume. The residue is then used to fill in low areas.

HOG FEEDING — The edible garbage is first cooked and then fed to hogs.

GRINDING — Machines grind up the garbage and dispose of it in septic tanks or municipal sewage treatment plants. This method

leaves the problem of how to dispose of dry refuse and trash.

SANITARY LANDFILL – This method provides for garbage and refuse to be placed in pits in the ground. A heavy machine is run over it to compact (or crush) it into a smaller mass and it is then covered with earth. This provides for sanitary disposal and also allows unusable land to be reclaimed for other purposes.

"BURIAL AT SEA" – This is practised only by several of the larger northern cities and is too expensive for smaller cities here in Florida.

Storage

Storage of garbage is always a problem. The housewife is usually safe with a galvanized metal can of the ten or twenty gallon type which can be covered tightly. Without the cover, flies, rats, and other undesirable creatures are attracted to it and disease might result, such as dysentery. Cans of this size and type are fairly easily handled and most people can manage to put them out for the collector.

Small business establishments can use the same type of can very successfully but the larger establishments, such as super-markets and restaurants, may find it necessary to use some other type of storage due to the quantity of waste and the difficulty of storing it until collection is made. Many of these places provide screened areas adjoining the main building. The screens prevent the breeding of flies and the attraction of other vermin. The screened area also provides a central point for proper collection.

The Miami Beach hotels might be a good example of how to overcome difficult storage problems. Here the land is so valuable that they cannot build outdoor storage areas. Also, in order to protect the atmosphere of elegance at the hotels they must do everything in their power not to offend their guests. The solution at these hotels has been to provide refrigerated garbage storage rooms at ground level. Also, many apartment houses and business establishments have provided huge steel containers into which garbage can be placed from the ten and twenty gallon containers. These large containers are then picked up by lift trucks and moved directly to the disposal areas.

Most municipalities have regular garbage collection times – usually a daily pick-up at homes and business establishments. However, where some of our newer subdivisions have gone up there is no municipal pick-up and the contract garbage collector is available with his services. Usually the pick-up is made about three times each week and it is up to the collector to properly dispose of the wastes. An interesting sidelight to this is

the fact that it has been learned that about 50 per cent of the cost of collection can be saved if the home owners place the garbage cans at curbside.

When a community is looking about for a good garbage disposal system it should take many things into consideration. Not all cities or communities are alike so the various methods now approved as good sanitary practice should be surveyed for the most efficient one to fit the particular need.

Incinerators are very efficient affairs. They not only burn the garbage in huge furnaces but have after-burners in the smoke stacks that almost completely burn up the gases, and with it, the odors of the burning process.

Where the collectors use the garbage for *hog feeding* they are required by law to first cook it before feeding it to the animals. By cooking it they destroy the organisms that cause trichinosis and another disease peculiar to hogs, *vesicular exanthema,* which a few years back killed thousands and thousands of hogs in the southern part of the United States.

Feeding cooked garbage to hogs is a profitable business. A hog fed cooked garbage will gain from one-half to one pound per day in weight and these animals are available in our program of food production.

Some homes are now equipped with sinks having attached *garbage grinders* which grind up the wet garbage which is carried from the house to a septic tank on the property or to a municipal sewerage system. Unfortunately, many people in subdivisions have added garbage grinders to their homes only to find they have overloaded the capacity of their septic tanks. It has been found advisable to increase the capacity of septic tanks 25 to 50 per cent and increase the capacity of municipal treatment plants where garbage grinders are used.

Here in Florida a great many communities have begun to use the *sanitary landfill* method of garbage disposal. Actually, it is the system where garbage is concentrated and isolated and at the same time unusable land is reclaimed for profitable use. The garbage is trucked to areas where the land is not usable because it is low, swampy, or where a previous excavation of some sort has left a large hole to be filled. Here the garbage is dumped into pits which are carefully planned in advance. After a truckload is dumped, a tractor, or compactor, is run back and forth over it mashing it down to about a third of its original volume. It is then covered with a layer of dirt about two feet thick. This is also compacted. Another layer of garbage and another layer of dirt are added until the low area reaches the level of the surround-

(Continued on Page 97)

This supermarket shows the wrong way to store garbage. Cans without lids, unkempt storage area, and general unsanitary conditions attract flies, rats and vermin.

No matter how your supermarket looks inside, if you find a situation like this in back of it you wonder if the management is good. This store is outside the city limits and is served by a contract garbage collector.

Garbage and trash litter the rear of this supermarket. Odds and ends of wet garbage, such as vegetable trimmings, meat trimmings, and other unsanitary items are permitted to sour and attract vermin.

This situation is an eyesore to neighbors and constitutes a fire hazard also. The winds carry offensive odors about the neighborhood and make it unpleasant for the residents.

Poor garbage and trash storage.

A situation like this reflects both poor management and bad garbage collection service. You might be interested in looking in back of your favorite supermarket.

Shown within the white square above is the refrigerated garbage storage room. Here the garbage is stored under favorable conditions and is readily accesible to the collector. Arrow indicates the cooling unit on roof of storage room.

Careful thought went into this construction. Notice that the garbage storage room is separate from the main part of the building, is on the level of the street for easy access to the collection truck, and is placed by a drain so it can be periodically washed out and cleansed thoroughly.

The cooling unit used in this refrigerated garbage storage room is checked by the restaurant owner. In this case the unit is inside the room. The restaurant is one of Daytona Beach's finer eating places.

Although garbage and trash at this dump are eventually covered with earth, too much is allowed to accumulate first. Coverage should always be done as soon as the refuse is compacted, or crushed, and leveled.

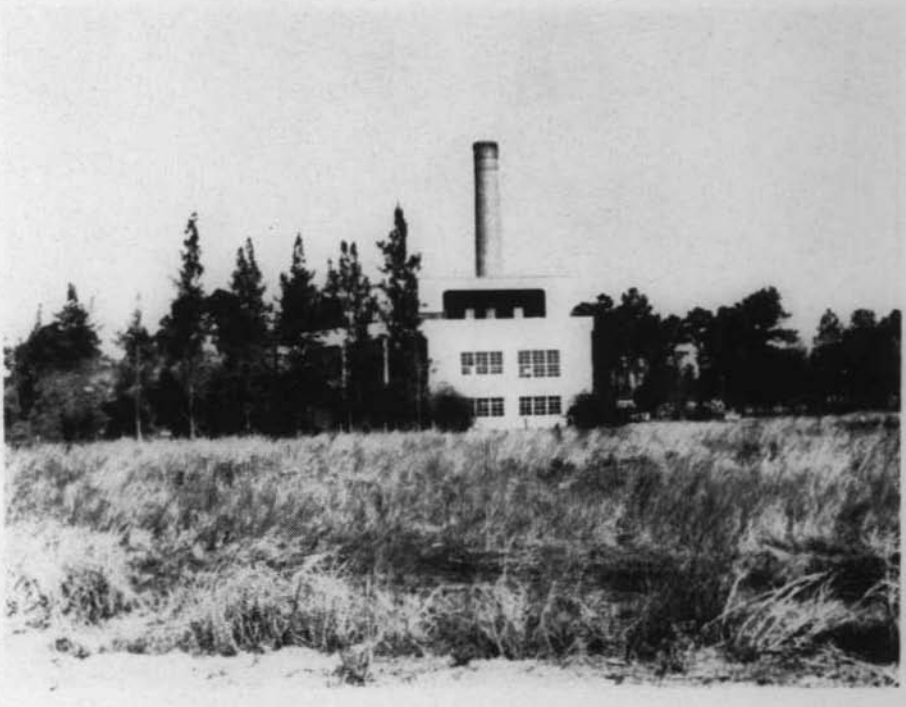
In this case the compacting is done at irregular intervals allowing water to collect in cans and other containers. This makes possible the breeding of flies and mosquitoes and provides hiding places for rats.

The City of Chiefland purchased garbage cans two years ago, had the bottoms of them coated with tar, and gave them to each home and business establishment. Levy County Sanitarian demonstrates can chosen at random to show how the tar coating counteracts the acids in the garbage. The bottom of this can has never rusted.

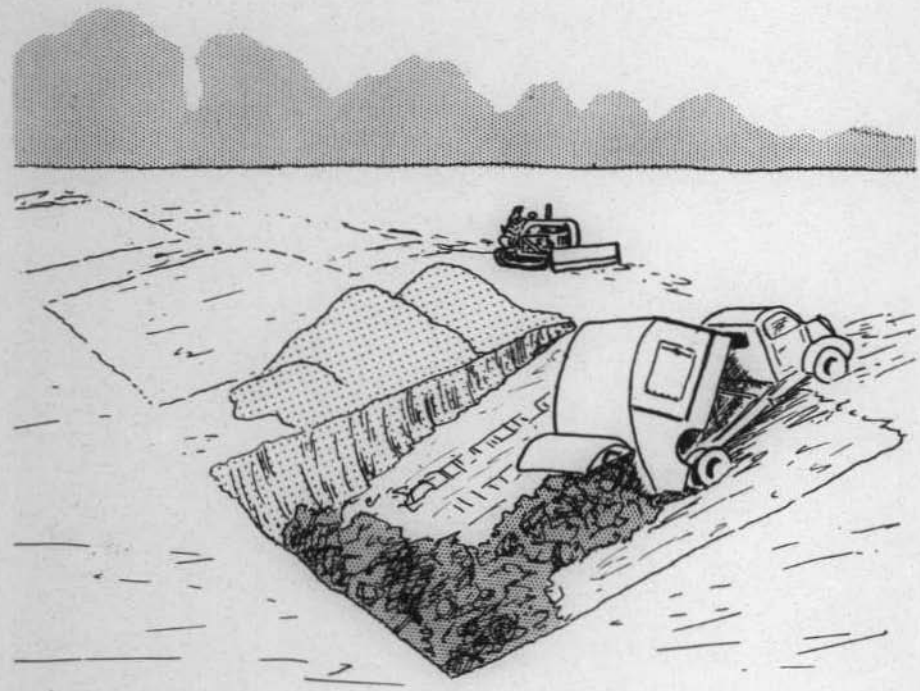
Other communities which may be interested in this project may secure the information they desire by dropping a line to the Levy County Health Department or to the City of Chiefland.

Many Florida cities are using this system for storage of garbage in areas where several business establishments are located. All the stores and restaurants in this shopping center place their garbage in this container which is periodically picked up by a collection truck, carried to the incinerator, dumped, and returned for more garbage and trash.

Note that this system eliminates the untidy conditions as found on pages 83, 84, and 85. This storage container serves eleven business establishments at one time and still has the capacity to prevent scattering of refuse all over the premises.



This incinerator is used by one of Florida's larger cities. Trucks drive up the incline seen through the trees at left. They dump their loads of garbage and trash into an immense hopper near the top of the building. The refuse is then fed from the hopper into a giant furnace which burns it at intense heat. The garbage is so well consumed by the flames that no odors and practically no smoke come from the tall chimney.



This drawing shows how a sanitary landfill disposal system operates. The truck backs down into the pit scooped out by a bulldozer. The garbage is then dumped from the truck. The bulldozer then rolls backward and forward over the garbage crushing it into a space about one-fourth as large as it originally occupied. It is then covered with a layer of dirt and the process is repeated until the pit is level with the surrounding area. At left may be seen the outline of two pits already filled and leveled. This system permits unusable land to be reclaimed for future use as playgrounds, parking areas, or any other useful purpose.

The sanitary landfill is a very economical method of garbage disposal that may be used by both large and small communities. This one small bulldozer is used by several small communities in Levy county. It is loaded onto the truck and hauled to the landfill area periodically during each week. Here it is being driven from the truck preparatory to compacting and covering the garbage pickup awaiting it in the landfill area.

City-owned collection truck is dumping garbage into the pit. When it is unloaded the bulldozer will compact the garbage and cover it.

Many small communities are realizing the value of the sanitary landfill method and the relatively small expense makes good sanitation possible for almost any town. Your County Health Officer can help you if your city is looking for a good garbage disposal system.

This compactor truck (one which has an attachment to pack the garbage as it collects it and thus make room for more garbage) dumps its load into a sanitary landfill pit at Gainesville.

The trucks used by municipalities to pick up garbage are marvels of engineering. They have built-in compactors which press the loosely packed garbage into the body of the truck so it can hold more and be used more efficiently. It is then taken to the disposal site and used for sanitary landfills, incinerated, or otherwise disposed of.

The experiment that failed. This view shows the dilapidated and no longer used concrete "digester" pits where wet garbage was sorted from the trash and dry garbage. It was then placed in these pits, sealed up air-tight and allowed to remain for several weeks. The bacterial action in the garbage created heat which "cooked" it and when the pits were opened the residue was bagged and sold for fertilizer. Although many bags were sold when the plan was put into operation, developments in commercial fertilizers made the project unprofitable. The cooking pits were then abandoned to the elements.

This view shows approximately one-third of the area of land that has been reclaimed from swampland at Gainesville. The sanitary landfill method here has taken about eight years to fill in this area, which is now used as a parking area for the local baseball stadium.

ing territory. Cells are sometimes dug in the ground about eight feet deep. The layers of garbage and earth are compacted until they reach the level of the surrounding ground. The cells are usually separated by a two or three foot space so that if one cell should catch fire the others will not be affected by it and the fire can be properly controlled to prevent causing a nuisance.

Many times there are low swampy areas that cannot be dug out so the garbage is dumped at compacted by a tractor. An earth cover is then put over the compacted garbage and the end result is to have the low marshy area completely covered with earth, reclaiming it for valuable future use. There have been examples where the edge of the marshy area and is airports, playgrounds and parking areas have been located over these sanitary landfills, making good use of what were formerly eyesores.

Sanitary landfill is an efficient operation. With proper planning it will usually cost less than half

as much to operate as an incinerator. In addition, the reclaimed land has a very definite value. In Florida this system is gaining popularity and because it has such a wonderful potential for controlling the breeding of flies and other vermin it can be of value to a community in another way. Communities wishing to use the sanitary landfill disposal method can incorporate it into their mosquito control program and participate in state funds to locally reduce the cost of both garbage disposal and insect control.

Some home owners use a small version of the landfill method at their homes. They simply dig a small but deep hole, throw in the garbage, pack it down good and then cover it with dirt from the hole. Disposal of *garbage* by home incinerators is usually not satisfactory, although *refuse* from the home is usually dry and burns easily. Wet garbage presents a problem since it usually does not burn easily, smokes quite badly, is odorous and offensive to the family and neighbors. Some home incinerators have built-in gas burners to effect complete disposal of the garbage. A large western city has found that the smoke from backyard incinerators combined with the natural fog helps to form the smog for which the city has become "famous." They have had a campaign to rid the area of backyard incinerators.

What's Your Problem?

If your community is one of the many in Florida that is feeling the pangs of population growth, you might be interested in the disposal systems described above. Rapid growth and the constant increase in the number of families moving in from out of state make it important to any community to give serious thought to future planning for good garbage disposal. Citizens should be looking for land that needs filling or for areas that would lend themselves to the advantage to be gained from using the sanitary landfill method. The County Health Officer, who is the director of the County Health Department, with his sanitarians, will be glad to assist in any way if your city government is planning to expand or revamp its present garbage disposal system. Or you can write the Bureau of Sanitary Engineering, Florida State Board of Health, Jacksonville, Florida.

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Wade N. Stephens, M.D., M.P.H.
Assistant Director

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Ruth E. Mettinger, R.N.

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Fred B. Ragland, B.S.

Bureau of Vital Statistics
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Bureau of Dental Health
Floyd H. DeCamp, D.D.S.

Bureau of Narcotics
Frank S. Castor, Ph.G.

Bureau of Laboratories
Nathan J. Schneider, Ph.D., Acting

Bureau of Sanitary Engineering
David B. Lee, M.S., Eng.

Bureau of Preventable Diseases
C. M. Sharp, M.D.

Epidemiologist
James O. Bond, M.D., M.P.H.

Division of Venereal Disease Control

Division of Tuberculosis Control

Division of Veterinary Public Health
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Division of Industrial Hygiene
John M. McDonald, M.D.

Bureau of Special Health Services
L. L. Parks, M.D., M.P.H.
Division of Hospitals & Nursing Homes

Division of Chronic Diseases
Heart, Cancer and Diabetes
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of Heart Disease Control Program

Division of Nutrition
Chief Nutrition Consultant
Marjorie Morrison, M.S.

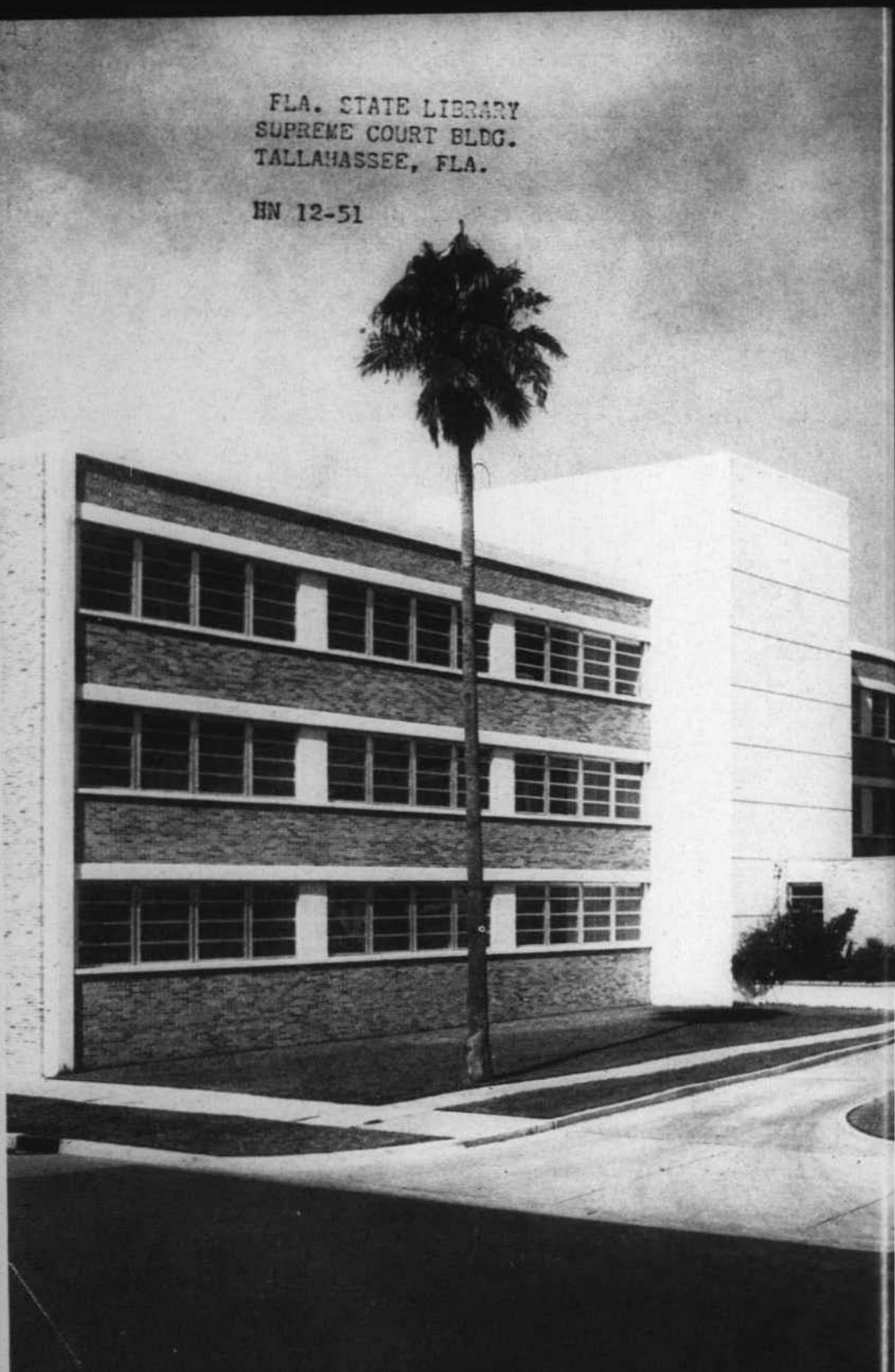
Bureau of Maternal & Child Health
Edward L. Flemming, Ed.D., Acting

Bureau of Mental Health
Melvin P. Reid, Ph.D., Acting

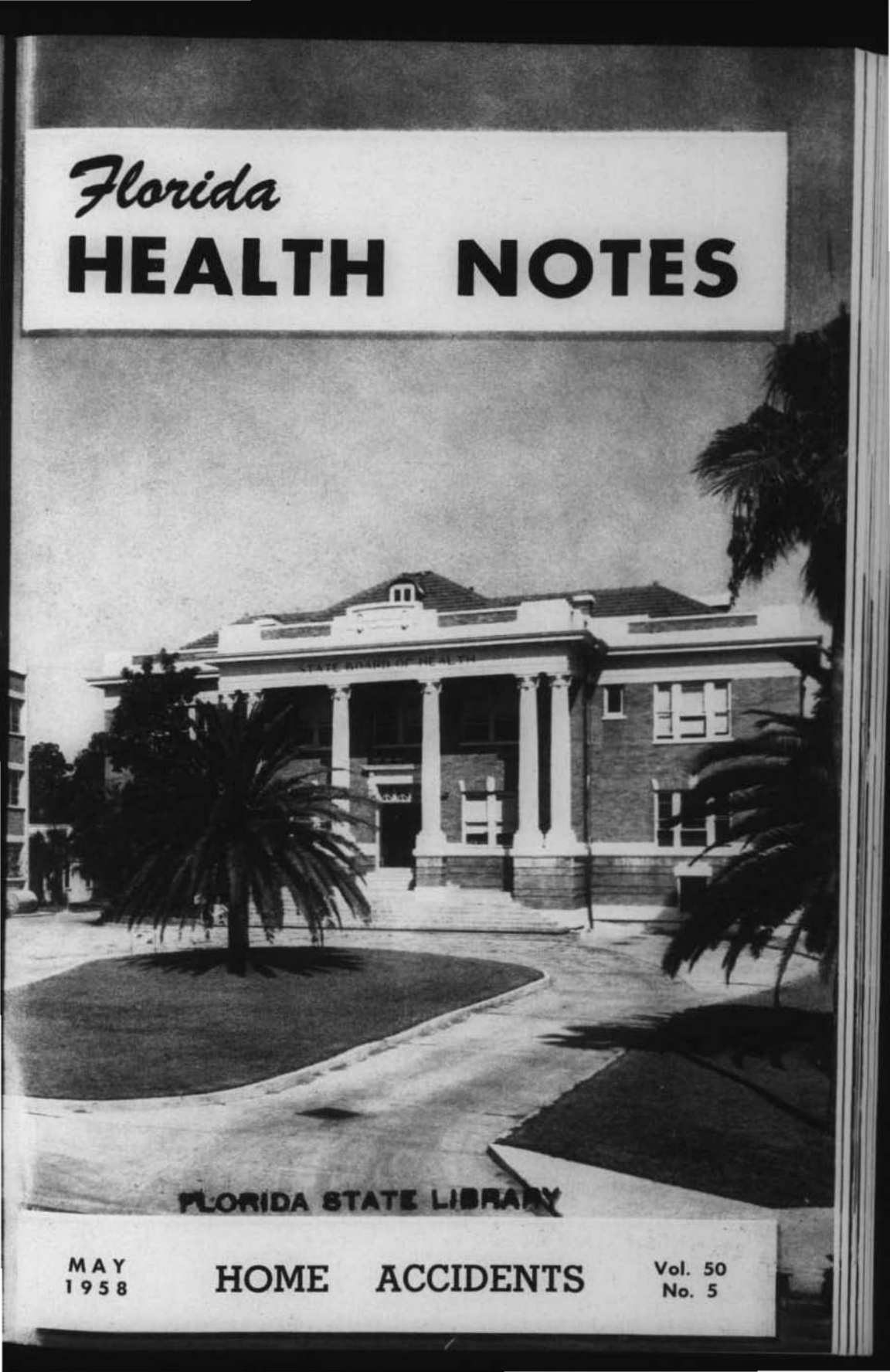
Bureau of Entomology
John A. Mulrennan, B.S.A.

All Counties in Florida have organized county health departments, except St. Johns County

FLORIDA HEALTH NOTES published by Florida State Board of Health since 1892



Florida HEALTH NOTES



MAY 1958

HOME ACCIDENTS

Vol. 50 No. 5

"HOME, SAFE HOME?"

Home – beloved of poets and songwriters, place of safe haven for the family, for which all wars have been fought – a truly wonderful place.

But it is also a place where you can be killed, maimed, or hurt badly in a fraction of a second if you don't try to prevent the many potential accidents before they happen.

HOME ACCIDENTS

In 1956 accidents killed 2504 people in Florida. Of this figure 1125, a little less than half, were deaths resulting from automobile accidents. The rest of the total, 1379, resulted from what has been loosely termed "other accidents." The number of "other accidents" which happened in the home is an awesome number.

And remember, it is estimated that *for each accidental death there are 10 persons injured* from accidental causes. This means that there were approximately 13,800 Floridians injured last year from causes other than automobile accidents. These injuries varied from relatively minor bumps, cuts, and bruises to seriously injured persons who were fortunate to still be alive but who may forever be crippled.

Let us look at some of the common hazards found in almost any home – yours included – and see how they can be serious not only to the real victim but also to the entire family.

We are starting with a hypothetical accident to an average man and will follow it through the possible, even probable consequences to himself and his family.

FLORIDA HEALTH NOTES

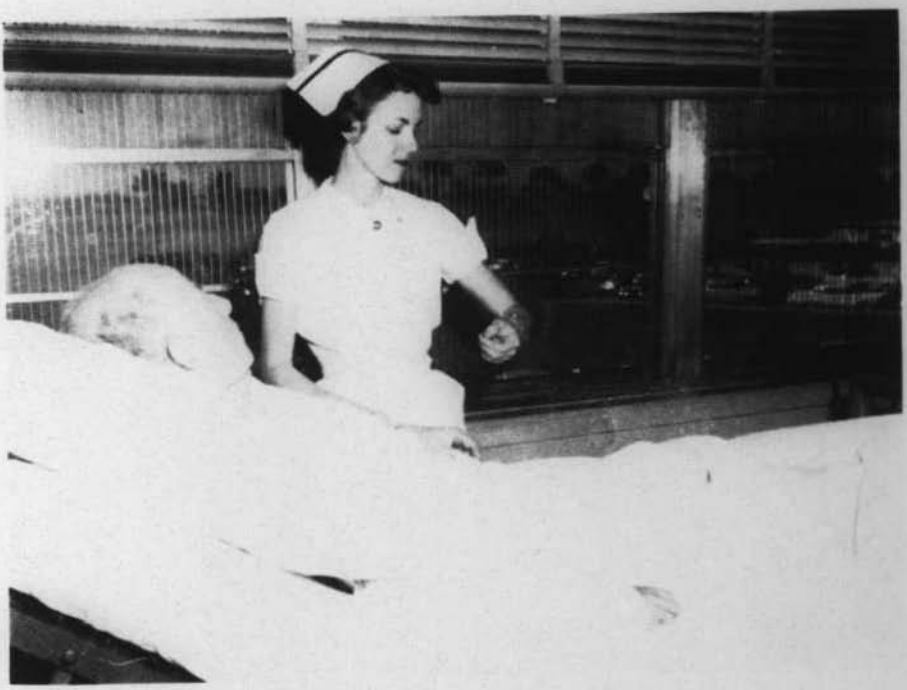
Published monthly except July and August on the 5th of the month by the Florida State Board of Health. Publication office, Jacksonville, Fla., headquarters of the State Board of Health. Entered as second class matter, Oct. 27, 1921, at post office, Jacksonville, Fla., Act of Aug. 24, 1912. It is intended primarily for individuals and institutions with an interest in the state health program, public and private. Permission is given to quote any story. Clipping of quotations or excerpts would be appreciated.

Here we see the husband and breadwinner entering his "home, safe home" after a day's hard work. As he enters the living room he slips on that throw rug and "accidentally" breaks his arm and injures his back.

In December of 1957 the Dade County Health Department and the Dade County Board of Public Instruction conducted a joint survey which revealed that 15.4 per cent of the homes surveyed contained just such hazards as that shown above.

This victim was rather lucky – his hospital stay lasted only four days and then he was released to go home and wait until he was able to return to work.

Let's presume that he was a foresighted person and carried hospitalization insurance so he has to pay only a small amount of his bill – or perhaps his insurance covers all his hospital expenses for these four days.



The short hospital stay passed quickly but he soon learns that he will have to stay at home until his broken arm knits and his back is well enough to permit him to stand and move around with ease. So, here at home he stays – and frets – for long weeks.

He thoroughly enjoys the attention showered on him by members of his family – BUT ———

Since the man can no longer work, the family's income may stop. The paychecks no longer come in, the savings account dwindles away, the normal cost of living goes on just the same PLUS the added expense of the injury. The bills begin to pile up and they must be paid some way.

If the savings run out before the bills are paid, perhaps the wife must then become the breadwinner and seek work outside the home.

This can lead to additional expense since the wife may now prepare less economical meals since she has to fix them in a hurry; there is more laundry to be sent out; transportation costs for the wife, and so on. Besides, worry and the long hard hours are not always the best for his wife's health and she may find herself ill as a result.

This whole series of unfortunate events could have been easily PREVENTED. There need not have been an accident in the first place.

But, you say, throw rugs will slip and what can you do about it?

The answer is quite simple. Bits of scrap rubber can be glued to the back of each rug, one in the center and one at each corner, and thereby greatly reduce the slipping hazard of accidents from this cause.

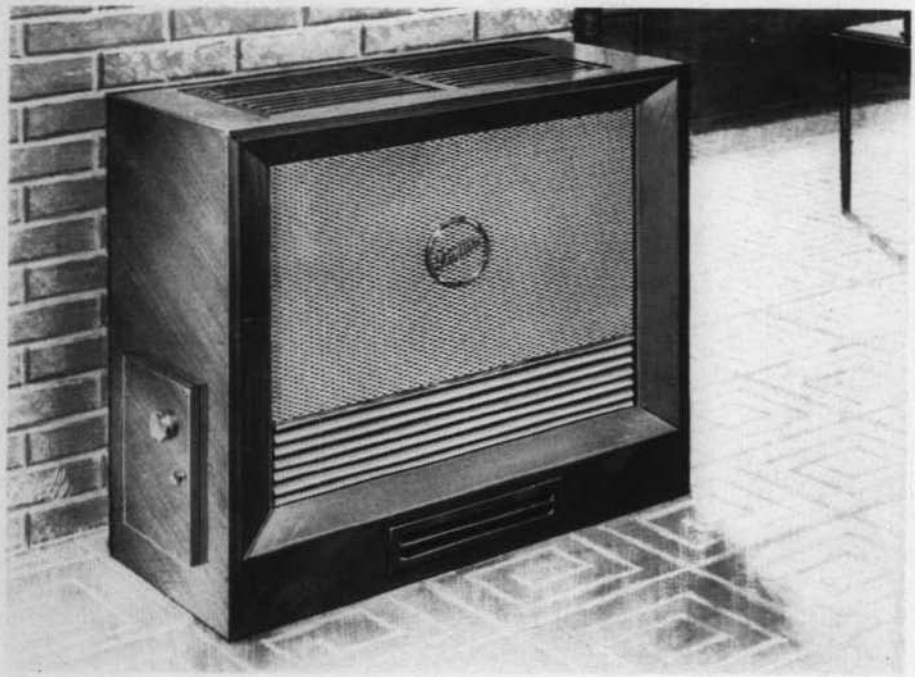
The "Do-it-yourself" trend of late has brought power tools of all kinds into the homes and garages of many people. But these tools are no respecters of persons. It makes no difference whether you shove a board – or a hand – against them, they will try to do their job well – such as this saw which has just cut into the user's hand.

NEVER forget that power tools – especially saws and other cutting tools – are dangerous and will cut anything that touches them.

ALWAYS arrange to keep your hands away from the business end of these tools.

Stools, chairs, coffee tables, in fact almost any piece of low furniture is handy for stepping up on to reach high places, such as adjusting the curtains. But these kinds of furniture were *not* designed for climbing on and are easily, too easily, tipped over with consequent disaster for the thoughtless person.

Our victim here is reenacting an actual fall she sustained in her home as a result of trying to use the overturned footstool as a ladder.



Carbon monoxide is a deadly weapon, whether caused by automobile exhaust fumes, chemicals, or improperly adjusted appliances.

Probably the greatest reason for accidents involving home heaters and heating appliances is the lack of knowledge by the user and the lack of familiarity with the uses.

Unless an inside gas heater has a smoke pipe leading to the outside air it can fill the room with deadly gases, and unless the room is well ventilated, cut down the oxygen content of the air to the extent that it can make one ill – or even cause death.

Unvented appliances should be carefully inspected periodically by a qualified person to insure proper operation.

Some accidents are caused by just plain carelessness. It would be so easy to pick up this broken jar now, before the child is hurt. Picking up the jagged glass *after* that little bare foot is badly cut will be too late.

DEATHS BY ACCIDENTS

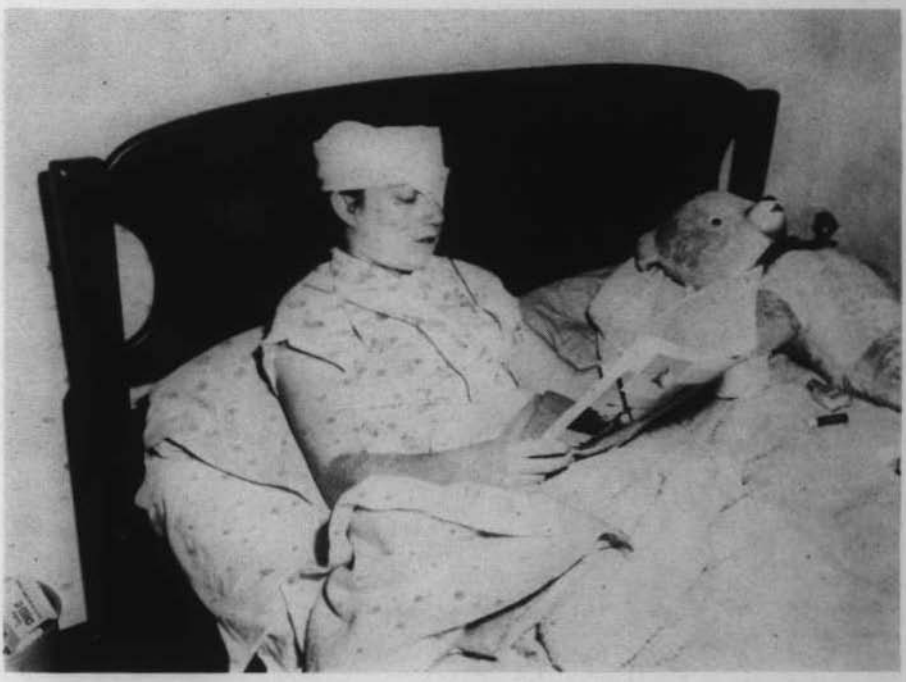
2504 PEOPLE DIED IN FLORIDA DURING 1956

CAUSE – ACCIDENTS

National Total

1955 – 93,443 deaths from accidents

1956 – 94,350 deaths from accidents



ACCIDENTAL INJURIES

25,000 WERE INJURED BY ACCIDENTS IN FLORIDA IN 1956

National Total

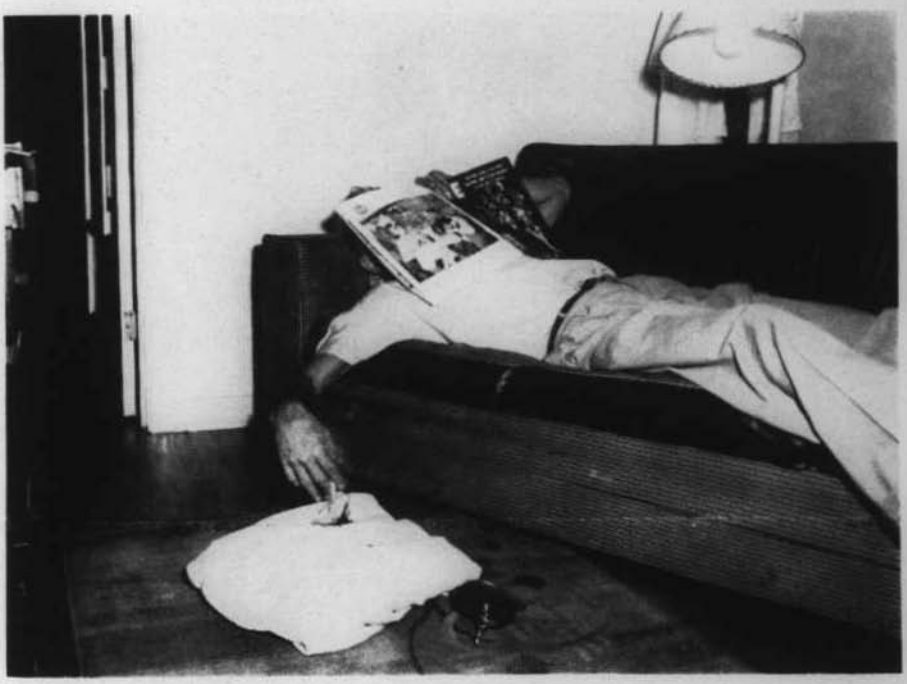
55,000 people injured each year

1,500,000 people hospitalized each year

Garden tools are not especially dangerous – except as illustrated above But they are sometimes carelessly handled and can cause serious cuts or bruises. This applies both to such tools as rakes, hoes, and shovels. Also to lawnmowers, both hand and power types.

The greatest single cause of fires in homes is careless smoking and improper use of matches. The most dangerous of these is smoking in bed or on a couch. The smoker dozes off and the fire gets a start before he awakens.

The Dade County survey showed that 14.6 per cent of the residents of that county do smoke in bed, so we may reasonably assume that an equal percentage of the rest of the state population also makes this mistake.



The second greatest cause of home fires is the misuse of electricity. The wiring in a new home is safe when it is installed. Home repairs and changes make it unsafe. Old wiring should be checked by an expert.

A penny placed behind a fuse is one common type of quick "repair." This one cent piece will carry 120 amperes of electricity, but the average home is wired to be safe for 15 amperes.

Any comment?

Poisoning is another form of an all-too-common accident.

Between July 1956 and July 1957 the 16 poison control centers in Florida alone handled 736 cases of accidental poisonings. There were, in addition, several hundred phone calls to these centers from private physicians asking how to treat other poisoning cases seen in their offices or at the patient's home.

The Dade County survey showed that 4.4 per cent of homes did not properly safeguard medicines – and kids do like to play doctor – realistically.

The answer to this problem can be found in the instructions on the following page.

HOW TO PREVENT ACCIDENTAL POISONING IN YOUR HOME

KEEP ALL DRUGS, POISONOUS SUBSTANCES, AND HOUSEHOLD CHEMICALS OUT OF REACH OF CHILDREN AND UNDER LOCK AND KEY IF NECESSARY.

ALWAYS STORE NONEDIBLE PRODUCTS IN THEIR ORIGINAL CONTAINERS; DO NOT TRANSFER THEM TO UNLABELED CONTAINERS.

WHEN MEDICINES ARE DISCARDED, DESTROY THEM. DO NOT THROW THEM WHERE THEY MIGHT BE REACHED BY CHILDREN OR PETS.

WHEN GIVING FLAVORED AND/OR BRIGHTLY COLORED MEDICINE TO CHILDREN, ALWAYS REFER TO IT AS MEDICINE – NOT AS CANDY.

DO NOT TAKE OR GIVE MEDICINE IN THE DARK.

READ LABELS BEFORE USING CHEMICAL PRODUCTS.

Health Notes is indebted to the American Medical Association for these simple rules.

Just as kids like to play doctor they also like to play cowboys and/or cops and robbers – and what is more fascinating than papa's real gun?

To be safe, guns must be unloaded and *locked up* at all times.

PREVENTION

By Joseph Melin

"Twas a dangerous cliff, as they freely confessed,
Though to walk near its crest was so pleasant,
But over its terrible edge there had slipped
A duke and fully many a peasant.
So the people said something would have to be done
But their projects did not all tally.
Some said "Put a fence around the edge of the cliff."
Some, "An ambulance down in the valley."

But the cry for the ambulance carried the day,
And it spread through the neighboring city;
A fence may be useful or not, it is true,
But each heart became brim full of pity.
For those who slipped over the dangerous cliff,
And dwellers in highway and alley
Gave pounds or gave pence, not to put up a fence,
But an ambulance down in the valley.

Then an old sage remarked "It's a marvel to me
That people give far more attention
To repairing results than to stopping the cause,
When they'd better aim at prevention."
"Let us stop at its source all this mischief," cried he,
"Come neighbors and friends; let us rally.
If the cliff we will fence, we might almost dispense
With the ambulance down in the valley."

"Oh, he's a fanatic," the others rejoined;
"Dispense with the ambulance? Never!
He'd dispense with all charities, too, if he could.
No, no, we'll support them forever!
Aren't we picking up folks just as fast as they fall?
And shall this man dictate to us? Shall he?
Why should people of sense stop to put up a fence
While the ambulance works in the valley?"

But a sensible few, who are practical too,
Will not bear with such nonsense much longer,
They believe that prevention is better than cure,
And their party will soon be the stronger.
Encourage them, then, with your purse, voice and pen
And while other philanthropists dally
They will scorn all pretense and put up a stout fence
On the cliff that hangs over the valley.

FLORIDA STATE BOARD OF HEALTH

1217 Pearl Street or P. O. Box 210

JACKSONVILLE, FLORIDA

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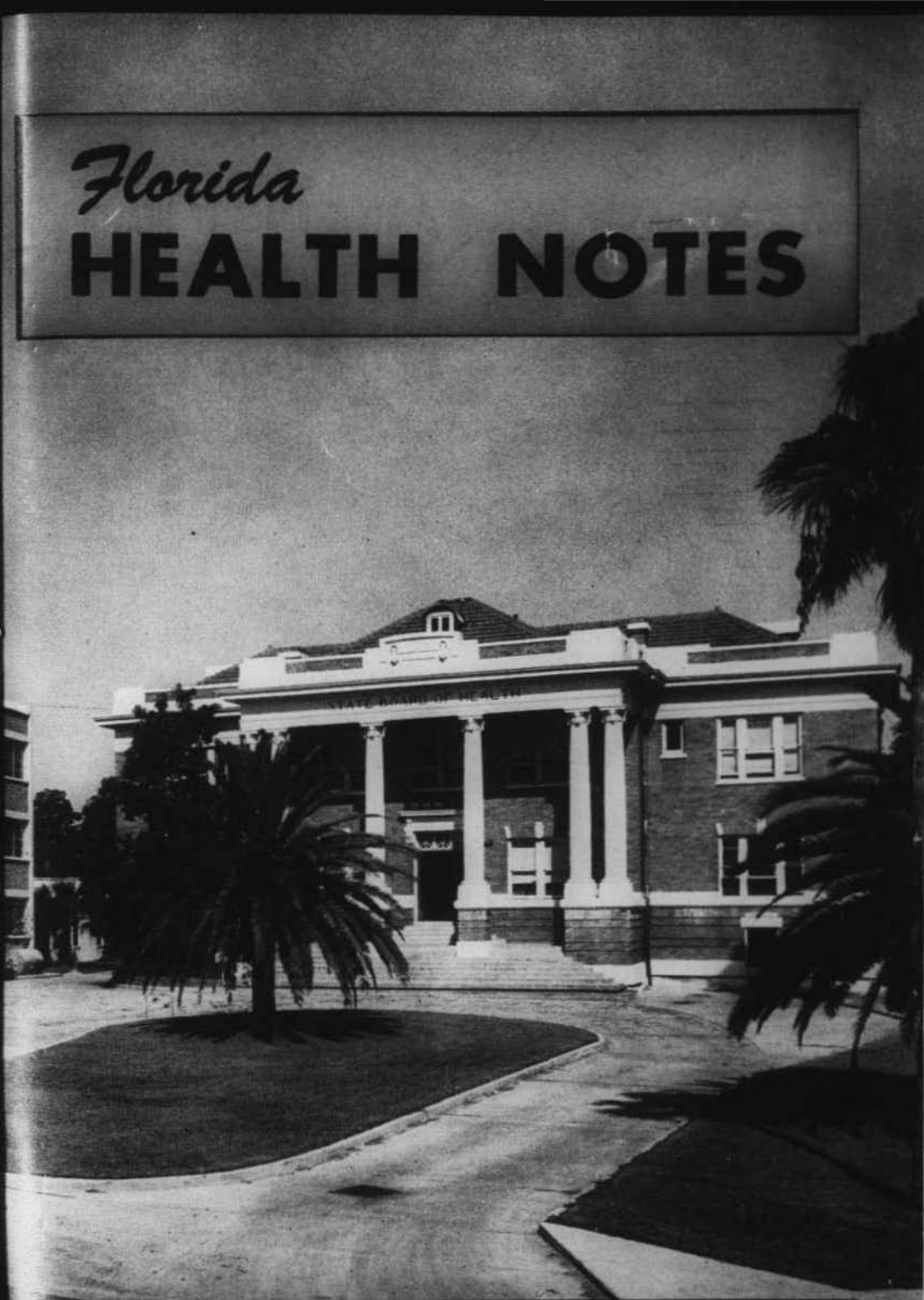
Florida HEALTH NOTES



JUNE 1958

1957 IN REVIEW

Vol. 50 No. 6

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State Health Officer

1957 IN REVIEW

Each year the State Board of Health publishes an official Annual Report. It is a thick volume containing much detail and many statistics and goes to colleges and universities, libraries and state health departments, federal agencies and Florida's official and voluntary health agencies, including County Health Departments. There is much in this volume, however, that is of interest to you, the Florida citizen. So we try to pick out those parts of the report which we think would have meaning for you and make this condensation the June issue of *Florida Health Notes.*

If you should desire further information about any facts you read herein, visit your nearest County Health Department and ask to look at their copy of the Annual Report, or write the Division of Health Information, P. O. Box 210, Jacksonville, Florida, and we'll tell you where the nearest one may be viewed.

We hope you will enjoy this short recital of a *few* things that happened in public health in Florida in 1957. For whether you realize it or not, many of them touched *your* life.

FLORIDA HEALTH NOTES

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GENERAL SUMMARY

The ability of an organization to keep abreast of changing times and trends and their effect on the public health, testifies to its progress siveness. The State Board of Health, it is hoped, has this ability. The appointment of a Coordinator of Research late in 1956, and the expansion of our research projects in 1957, shows our concern for more accurate background information on which to base new public health programs or to expand old ones.

The State Legislature has increasingly made the State Board of Health an advisor to, or an activator of, various programs in which it is interested and in which there are public health aspects. Many of these programs have advisory committees. The following are set up by legislative acts: Florida Air Pollution Control Commission, Florida Council on Training and Research in Mental Health, Dental Scholarship Advisory Committee, Hospital Licensure Advisory Council, Medical Scholarship Advisory Committee, and Advisory Committee for Hospital Service for the Indigent.

Many of the above groups require that the State Health Officer participate in their meetings or otherwise aid them in their problem solving. Also added to his other responsibilities are numerous requests from state and voluntary agencies and professional societies to attend their meetings. It became increasingly obvious that the State Health Officer needed assistance, so the Board of Health approved the appointment of the Coordinator of Research as Assistant State Health Officer. His primary responsibilities, in addition to coordinating research, are: to assist bureau and division directors, county health officers and others in program development, especially in new fields; evaluate old programs and assist the State Health Officer in determining relative emphasis to be placed on all programs; review training activities; and to foster personnel recruitment.

The Merit System Classification Plan and Salary Schedule went into effect on July 1, 1957. Numerous inequities were protested. The attendance at Merit System Council meetings and the voluminous correspondence required to put the Plan into operation have required a great deal of time by the State Health Officer and his staff. However, many problems concerning the Plan were resolved in 1957. The employment of a personnel technician, and a personnel officer in the Bureau of Local Health Service assisted greatly.

Employees of the State Board of Health and the County Health Departments were given the opportunity to participate in Federal Social Security which was included with State Retirement. Approximately 1174 of our employees chose to participate.

The communicable disease receiving the most attention in 1957 was Asian influenza. Florida was one of the first states to have laboratory confirmed cases of this strain of the disease. Apparently about ten per cent of Florida's population was affected. The epidemic was not as severe in Florida as elsewhere as the total recorded deaths for September, October, November and December were not in excess of the number expected.

Four new health centers were completed during 1957, as compared to seven during 1956. However, 14 were under construction at the end of the year (including one regional laboratory). Attractive, efficient offices are most important aspects of a County Health Department's administrative set-up, for dingy, poorly located quarters do not enhance the public's opinion of this phase of local government.

The following are projects completed last year under the Federal Hill-Burton Hospital and Health Center Construction Program:

Projects Completed During 1957	*Location*	*Federal Grant*	*Total Cost*
Lakeland Health Center	Lakeland	$33,441.60	$83,604.00
Calhoun County Health Center	Blountstown	32,299.47	63,794.80
Escambia County Health Center	Pensacola	222,620.35	472,729.93
Walton County Health Center	DeFuniak Spgs	42,250.00	65,105.00

ACTIVITIES OF THE BOARD

The governing body, the Board of Health, held five meetings during the year. Some of the items they discussed were:

January 12 — Key West

By resolution authorized and directed the State Health Officer to proceed with the construction of a new regional laboratory in Orlando.

At a public ceremony received a historic watch from the J. Y. Porter family which was given to J. Y. Porter, M.D., the first State Health Officer, by the Jacksonville Auxiliary Sanitary Association in 1889. Discussed septic tank problems in Monroe County with local citizenry.

February 12 — Jacksonville

Discussed revision of formula for determining state contributions to local health units for basic health services; whereby county contributions which are to be matched by state and federal funds will include only the local funds from official local agencies.

Discussed the Palm Beach property owned by the State Board of Health and the furnishing of office space to the Board in the proposed West Palm Beach Public Health Center.

May 5 — Hollywood Beach

Approved proposed applicants for postgraduate training.
Discussed the additional $125,000 needed for the completion of the new building in Jacksonville to be inserted in the Appropriations Act.

July 28 — Jacksonville

Discussed the principal enactments of the 1957 Legislature affecting public health, the most significant of which was the substantially increased appropriation to the Board of Health, an increase of 58 per cent.

Discussed the responsibilities and limitations of the State Board of Health in the administration of the Naturopathic Act of 1957.
Discussed the duties and responsibilities of the State Board of Health and the Air Pollution Commission in regard to the Air Pollution Act of 1957.

Discussed the Hospital Licensing Program and the Nursing Home Licensure Program for the 287 nursing homes licensed in the state.

October 13 — Jacksonville

Approved the appointment of Dr. Albert V. Hardy as Assistant State Health Officer and appointed Dr. Nathan Schneider as Acting Director of Laboratories in Dr. Hardy's absence from the Laboratory.

Granted a one year leave of absence for Mr. John Wakefield, Sanitary Engineer, so he could become Director of Water Resources under the Board of Conservation.

Discussed and approved proposed revision of regulations of the Structural Pest Control Act of 1947 (as amended – Chapter 482, Florida Statutes 1955).

RESEARCH AND DEMONSTRATION PROJECTS WITH APPROXIMATE ANNUAL COSTS AND AGENCY PROVIDING FUNDS

Modern State Health Departments are very much interested in research. The Florida State Board of Health is no exception. Following are listed some research projects in which we are interested:

Virological Etiology of Acute Enteric Infections	
National Foundation for Infantile Paralysis	$ 15,000
Armed Forces Epidemiological Board Laboratory	6,000
Rabies in Bats and Other Wild Life	
NIH, U.S. Public Health Service Laboratory and Veterinary P.H.	18,000
Infections Due to Atypical Acid Fast Bacilli	
School of Aviation Medicine	5,000
State TB Board	12,000
Laboratory and Epidemiology	6,000
Laboratory Surveillance of Poliomyelitis and Asian Influenza	
U.S. PHS (CDC) Contract Laboratory	10,800

Aerosol Technic in Bacteriological Diagnosis of Tuberculosis
NIH, U.S. PHS — 5,500
University of Miami Medical School
Laboratory

Rapid Bacteriological Diagnostic Procedures
School of Aviation Medicine Contract — 5,000
Laboratory

Influenza in Pinellas County
Epidemiology — 1,000
Pinellas County Health Department

Entomological Research Laboratory Basic Studies
Entomology — 155,000

Experimental Analysis of Migratory Behavior
NIH, U.S. PHS — 20,000
Entomological Research Laboratory

Comparative Analysis of Gregarian Behavior
NIH, U.S. PHS — 19,500
Entomological Research Laboratory

Biology of Brackish-Water Larvivorous Fish
NIH, U.S. PHS — 14,000
Entomological Research Laboratory

Prevalence of Congenital Heart Disease among children In State School for Blind
School of Aviation Medicine, Pensacola
Heart Disease Control — 2,500

Therapy in Ambulant Hypertensive Patients
Duval Medical Center
Heart Disease Control — 3,600

Incidence of Recurrence in known Rheumatics with and without prophylaxis
Florida Heart Association — 600
Heart Disease Control — 2,500

Mental Health Research
Council for Training and Research in Mental Health 29,000
Various Agencies

Volusia County School Mental Health Demonstration
National Institute of Mental Health 17,000
Mental Health and Volusia County H.D.

Home Care of the Mentally Retarded Child
Children's Bureau 40,000
Dade County Health Department

Health Service for Migratory Agricultural Laborers
Children's Bureau 54,900
M.C.H. and Palm Beach County Health Department

Demonstration Program for the Care of the Premature Infant
Children's Bureau 50,000
M.C.H. and Jackson Memorial Hospital

The Characteristics of Nursing Home Populations
University of Miami Medical School 3,600
Dade County Health Department
Bureau of Mental Health 7,000

Time and Cost Studies of Public Health Nursing
Regional Office U.S. PHS consultation
Nursing Division, Alachua & Pinellas
County Health Departments 1,000

Differentials in Male-Female Mortality
NIH, U.S. PHS 10,000
Administration

Organization and Administration of Public Health Research
NIH, U.S. PHS 22,000
Administration

PERSONNEL OFFICE

. . . . . held a referendum whereby the employees voted to include Social Security with their State Retirement Plan.

. . . . . reported an increase from 1584 employees at the end of 1956, to 1735 at the end of 1957.

. . . . . recorded 555 employments and 404 separations, including part-time personnel. Reasons for separation include marriage, pregnancy, transfer of husbands from area, completion of projects for which employed and acceptance of more profitable employment elsewhere.

. . . . . handled the granting of scholarships to applicants as follows: medical, 11; dental, 10; mental health (doctors, nurses, social workers, psychologists) 32; public health personnel, 30.

Bureau of Local Health Service

. . . . . reported an increase of 71 county health department employees over 1956. There are now 1216 employees on the county health departments' payrolls.

. . . . . three groups of sanitarians, comprising a total of 18 people, received twelve weeks' training in the State Board of Health's offices in Jacksonville.

. . . . . five counties operating food handlers schools reported a total of 5653 food handlers were issued certificates for attendance at schools.

Public Health Nursing

. . . . . 59 public health nurses and five county health officers made 48-hour visits to the state mental hospitals. This has been especially helpful in the local follow-up of persons released from these hospitals on furlough.

. . . . . many public health nurses attended a series of institutes sponsored by the Crippled Children's Commission.

. . . . . three scholarships were given to public health nurses for a three weeks' course in rehabilitation at Rusk Institute in New York.

. . . . . the trend to "combination services," whereby visiting nurse service is also given by public health nurses employed by County Health Departments has continued to spread throughout the state.

. . . . . at the request of the U.S. Public Health Service, public health nursing students from the Philippines and Costa Rica were assigned to County Health Departments to gain needed experience.

. . . . . a year-end tabulation showed that 31 per cent of the 150 public health nurses employed in Florida have had approved courses in public health; 32 graduates from university schools of nursing are now employed.

Division of Health Information

..... the Audio-Visual Aids department reported 5264 aids (films, filmstrips, slides, etc.) circulated which were shown 11,671 times to a total audience of 651,888.

..... in addition, 13 films were used in telecasts seen by an estimated 500,000 and 44 radio transcriptions were heard by an estimated 1,800,000.

..... the Exhibits Consultant reported a total of 296 units, consisting of exhibits, displays, signs, charts, maps, etc., were built or prepared in 1957.

..... the mailing list for the monthly bulletin, Florida Health Notes, continued to grow. More than 13,600 people receive the publication each month.

..... the Library circulated 15,481 items in 1957. Of this figure, 3341 books were loaned, as well as 9914 journals.

..... 250,000 pamphlets, still a popular source of health information, were distributed in 1957. Those on mental health continued to lead the list, as they have done for several years.

..... 26 teachers from 14 counties participated in the 1957 "Teachers' Project." They attended one of the following universities: Florida State University, University of Florida or Miami University. Each of these teachers also spent two weeks in their home counties learning about activities of the County Health Departments.

..... 24 foreign visitors from 15 different countries, representing a variety of public health backgrounds, were oriented, trained or informed.

..... this Division jumped into the TV-producing field by being responsible for seven one-half hour shows and assisting and consulting with those responsible for the six other programs in a 13-week schedule.

..... radio transcription discs with 24 spot announcements on them concerned with a variety of Florida's health problems were prepared. They had wide usage and it is anticipated that more will be prepared in 1958.

..... the staff conducted and attended scores of meetings of various types and gave numerous talks.

Bureau of Preventable Diseases

..... more cases of *influenza* were reported in 1957 than any other disease. Cases reported show that 10 per cent of the population were attacked.

..... reported cases of *polio* continued their dramatic fall, 134 cases were reported in 1957 as compared with 364 in 1956 and 466 in 1955. The paralytic rate dropped 63 per cent from the preceding year.

..... there were three instances of *food-borne disease outbreaks.*

..... only fourteen cases of *malaria* were reported, none of which were acquired in Florida.

..... infectious hepatitis showed a slight rise, the first in two years.

..... 736 cases of accidental *poisoning* were handled by the 16 poison control centers throughout the state in their first year of operation which ended July 1, 1957.

TUBERCULOSIS CONTROL

. . . . . more cases were discovered and hospitalized in 1957 than any other year.

. . . . . the tuberculosis death rate reached a new low of 6.1 per 100,000 population. This places Florida in an enviable position as the national average is 8.7 per 100,000.

. . . . . a total of 758,921 X-rays were made by mobile units and County Health Departments.

. . . . . 15,721 patients were examined by County Health Departments as "contacts" and "suspects," thereby discovering many additional cases of tuberculosis.

★ ★ ★

INDUSTRIAL HYGIENE

. . . . . 648 analyses were made, of which 290 were for lead in the blood or urine or in air samples from industrial environments. Air contamination by fluorides accounted for 54 samples.

. . . . . this Division cooperated with the U.S. Public Health Service in making a preliminary industrial hygiene study of working conditions in the phosphate processing plants.

. . . . . chemists of the Division assisted in analysis of paint used on toys to determine if enough lead was present to injure the health of children, but the results showed the amount of lead was negligible and of no consequence.

. . . . . this Division cooperated with the Public Health Service Radiation Surveillance network, taking samples from air filters daily to check for radiation fallout.

VENEREAL DISEASE

. . . . . infectious syphilis broke out in three places in Florida in 1957 with 43 cases diagnosed and treated.

. . . . . the selective bloodtesting program was carried out in 13 counties with 28,013 specimens tested and 1988, or seven per cent, reacting positively.

. . . . . 28,767 premarital blood tests were made of which 3.32 per cent, or 965, were positive for syphilis. It is significant that 36.7 per cent of total positive cases were of persons who did not know they had the disease.

★ ★ ★

VETERINARY PUBLIC HEALTH

. . . . . of 264,495 cattle tested for brucellosis (which causes undulant fever in humans), 3015 reactors were identified and removed, and 97,282 calves were vaccinated.

. . . . . bovine tuberculosis showed a marked increase due to an outbreak in nine of the larger dairies in south Florida. Of 147,098 cattle tested, 485 were found infected and were removed.

. . . . . 396 cases of Eastern Equine Encephalitis ("horse staggers") in horses and mules were reported. Two human cases were confirmed by laboratory diagnosis.

. . . . . 596 cattle, 498 dogs, 44 other animals and two humans were laboratory confirmed positive for leptospirosis (a highly fatal disease of dogs, and a serious economic disease of cattle and hogs), during the year.

Bureau of Vital Statistics

PRELIMINARY TOTALS OF RESIDENT DEATHS FROM CERTAIN CAUSES, BY COUNTY, FLORIDA, 1957

COUNTY	Maternal Deaths	Tuberculosis	Syphilis	Dysentery (All Forms)	Acute Poliomyelitis	Malignant Neoplasms (Cancer)	Diabetes	Anemias	Influenza & Pneumonia	Cardio-Vascular-Renal Diseases				Motor Vehicle Accidents	Other Accidents
										*Cerebral Vascular Disease	Heart Disease	Chronic Nephritis	All Other C.V.R. Disease		
STATE	62	260	121	11	6	6,065	505	94	1,264	4,777	14,269	383	1,358	1,087	1,561
Alachua	1	6	1	0	0	53	8	2	25	79	168	1	13	20	31
Baker	0	1	0	0	0	6	0	0	3	3	16	2	2	0	4
Bay	0	2	1	0	0	52	6	0	11	49	107	4	21	14	25
Bradford ...	0	2	0	0	0	11	1	0	8	20	45	1	3	5	4
Brevard	2	1	1	1	0	56	7	2	23	60	173	2	14	21	26
Broward ...	4	11	5	0	0	359	27	10	74	197	710	18	78	66	88
Calhoun ...	1	0	0	0	0	6	0	0	0	19	18	1	1	4	3
Charlotte ..	1	0	0	0	0	17	2	0	4	20	33	0	2	2	3
Citrus	0	0	0	0	0	10	0	0	0	12	42	1	1	3	5
Clay	1	0	0	0	0	14	1	0	10	16	35	0	6	7	3
Collier	0	0	0	0	0	12	0	0	4	10	25	3	3	6	3
Columbia ...	1	1	0	0	0	22	2	0	5	43	48	0	3	7	7
Dade	7	57	25	3	1	1,206	97	11	214	646	2,654	58	234	194	198
DeSoto	0	1	0	0	0	21	3	0	5	22	44	4	6	2	5
Dixie	0	0	0	0	0	7	1	0	5	10	11	1	2	2	7
Duval	2	44	20	1	0	531	35	12	115	437	1,047	38	139	83	151
Escambia	4	10	6	0	0	136	14	1	54	144	394	10	33	41	67
Flagler	2	0	0	0	0	8	2	0	1	9	9	1	3	0	8
Franklin ...	1	1	0	1	0	8	1	1	0	9	18	2	2	1	8
Gadsden ...	3	3	0	0	0	37	0	1	23	46	102	7	14	10	16
Gilchrist ...	0	0	0	0	0	1	0	0	0	3	10	0	0	2	1
Glades	0	0	0	0	0	1	0	0	0	3	10	1	1	0	1
Gulf	1	0	0	0	0	6	1	0	1	1	14	1	1	0	4
Hamilton ..	1	2	1	0	0	17	4	0	1	11	34	1	1	1	4
Hardee	0	1	1	0	0	16	4	0	7	10	39	1	8	3	6
Hendry	0	0	1	0	0	3	0	0	1	6	23	0	2	3	1
Hernando ..	0	1	1	0	0	17	2	0	5	14	27	2	4	4	3
Highlands ..	1	1	0	0	0	24	1	0	6	30	64	9	9	1	13
Hillsborough.	4	20	14	0	0	518	39	10	71	299	1,266	35	86	70	116
Holmes	0	1	0	0	0	20	1	1	1	18	34	1	2	3	9
Indian River	1	2	1	1	0	25	5	2	3	22	68	2	9	13	7
Jackson	1	1	0	0	0	24	1	1	6	42	91	4	12	11	16
Jefferson ...	0	1	0	0	0	15	2	1	5	23	41	0	2	2	3
Lafayette ...	0	0	0	0	0	3	0	0	2	2	11	0	1	2	3
Lake	1	5	2	0	0	82	14	1	22	70	221	7	16	23	25
Lee	1	2	3	0	0	65	5	2	10	51	132	1	15	12	11
Leon	0	0	2	1	1	58	4	1	21	74	136	4	19	11	22
Levy	1	0	1	0	0	8	1	0	12	16	63	1	1	3	5
Liberty	0	0	0	0	0	2	0	0	0	0	5	1	2	1	0
Madison	0	0	0	0	0	24	4	0	7	16	52	1	3	3	10
Manatee ...	2	4	1	1	0	108	7	1	22	96	277	12	24	8	19
Marion	1	1	2	0	0	71	4	2	12	66	189	6	18	13	21
Martin	0	1	0	0	0	16	0	0	10	18	43	0	4	5	10
Monroe	0	2	0	0	0	54	4	0	8	38	76	1	4	10	16
Nassau	2	2	0	0	0	13	2	1	4	13	37	0	4	4	5
Okaloosa ...	0	2	0	0	0	23	1	0	14	27	74	5	0	18	32
Okeechobee.	0	0	0	0	0	9	1	0	1	5	7	1	0	3	0
Orange	1	14	7	0	0	276	20	2	52	224	730	23	63	45	73
Osceola	0	0	0	0	0	24	4	3	8	37	118	2	6	4	5
Palm Beach.	2	12	0	1	1	327	34	3	46	212	677	13	62	77	71
Pasco	0	1	1	0	0	46	6	0	7	50	122	1	16	9	27
Pinellas	3	13	7	0	1	756	46	7	92	654	1,824	23	175	55	101
Polk	2	8	7	0	0	225	23	1	59	220	531	11	34	46	66
Putnam	1	1	1	0	1	30	2	2	13	36	107	16	12	7	14
St. Johns ...	1	3	1	0	0	33	1	0	12	57	82	3	21	9	19
St. Lucie ...	2	1	1	0	0	42	3	0	10	36	81	1	6	16	19
Santa Rosa .	0	2	0	0	0	21	1	0	9	22	69	4	3	7	3
Sarasota	0	3	3	0	0	132	9	2	20	70	266	5	24	11	35
Seminole ...	0	3	0	1	1	46	10	1	25	45	132	9	7	17	21
Sumter	0	0	0	0	0	14	1	1	6	20	40	2	6	5	4
Suwannee ..	0	1	1	0	0	15	2	2	13	34	52	2	8	5	4
Taylor	0	0	1	0	0	5	0	1	5	21	25	0	3	5	4
Union	2	1	0	0	0	6	0	1	3	5	15	1	2	4	1
Volusia	1	7	1	0	0	235	26	4	35	170	569	14	64	34	53
Wakulla	0	0	0	0	0	2	0	0	1	4	8	1	7	1	3
Walton	0	1	1	0	0	23	2	0	3	18	51	1	6	9	8
Washington.	0	0	0	0	0	12	1	1	9	17	27	0	5	4	5

*Includes all vascular lesions affecting the central nervous system.

Bureau of Laboratories

..... there were 2,629,425 examinations made on 1,238,382 specimens submitted to the laboratories in 1957.

..... there was an increase in the number of diphtheria positive specimens submitted for examination. Three hundred and seven cases appeared as compared with 150 in 1956, 141 in 1955, and 112 in 1954.

..... a high proportion of positives of hookworm, ascaris, enterobius and other intestinal parasites was found, as in 1956.

..... diagnostic services for virus infections continued its rapid growth in 1957. Exclusive of rabies, a total of 5053 specimens were submitted in 1957 as compared with 3004 in 1956.

..... the number of animals examined for rabies increased over the preceding year. An outbreak of fox rabies in northwest Florida accounted for a substantial portion of the increased number of positive animals. There were at total of 1545 animals examined for rabies. Rabies showed an increase in 1957 due to an outbreak in one county which accounted for 65 of the 112 cases confirmed in eight kinds of animals.

Bureau of Mental Health

..... during 1957, 4938 patients received diagnosis, treatment or another type of service from the 14 child guidance and community hygiene clinics.

.....28 per cent of the patients discharged in 1957 were 9 years of age or younger and 49 per cent were 13 years or younger.

Bureau of Sanitary Engineering

..... Health problems in the field of sanitary engineering increased greatly in number and magnitude due to the rapid growth in population.

..... population increase in the urban areas is reflected in the approval of water supply systems or extensions for over 300 subdivisions.

..... ultimate additional water supplies provided for through facilities constructed, or proposed for construction, in 1957 was slightly over 88 million gallons per day.

..... the number of water plants in operation in Florida now total over 600.

..... the use of household septic tanks on an indiscriminate and unrestricted basis in mass housing developments continues to be a major problem.

..... a total of 329 swimming pool projects were approved in 1957.

..... the total estimated cost of all sewerage projects approved during the year was $35,784,064, which provided new treatment capacity facilities for 264,263 additional persons with collection faiilities having capacity for 521,374 persons.

..... sanitary sewers are now available for serving 52.4 per cent of the state's population.

..... a total of 87 shellfish production certificates were issued during the year.

..... 588 tourist and trailer park permits were issued in 1957 bringing the total number of permits issued to 1272.

Bureau of Special Health Services

..... licensed 102 hospitals so they might participate in the State Welfare Department's public assistance program.
..... during the year 315 nursing homes were licensed with a bed capacity of 7366.

..... 5107 patients were given 51,095 days of hospitalization under the Hospital Service for the Indigent program.

..... Insulin was distributed to 2768 medically indigent individuals in 1957 as compared with 2566 in 1956.

..... the Heart Disease Control program held cardiovascular seminars in six major Florida cities which were attended by 500 nurses.

..... nutritionists visited and consulted with 88 different institutions in 1957, discussing and assisting with problems of group feeding.

Bureau of Dental Health

..... there were more requests for dental films than any other category of films in the audio-visual library

..... 5446 pieces of literature were distributed on the subject of fluoridation throughout the state. In addition, films, as well as radio and television programs were presented throughout the state on this subject.

..... 700 residents of twenty-one homes for the aged were carefully examined in connection with a survey being made by the U.S. Public Health Service.

Bureau of Narcotics

..... during 1957, 168 arrests were made for violation of the narcotic law, an increase of 22 over 1956.

.... inspectors traveled 167,756 miles investigating 3046 hospitals, pharmacies, and other handlers of drugs and narcotics; 1340 investigations of suspected violations were made.

..... there were 7609 practitioners of the healing arts registered in 1957 as compared with 7053 in 1956, an increase of 556.

..... Medical doctors registered by the narcotics bureau numbered 6066 — an increase of 406 over 1956.

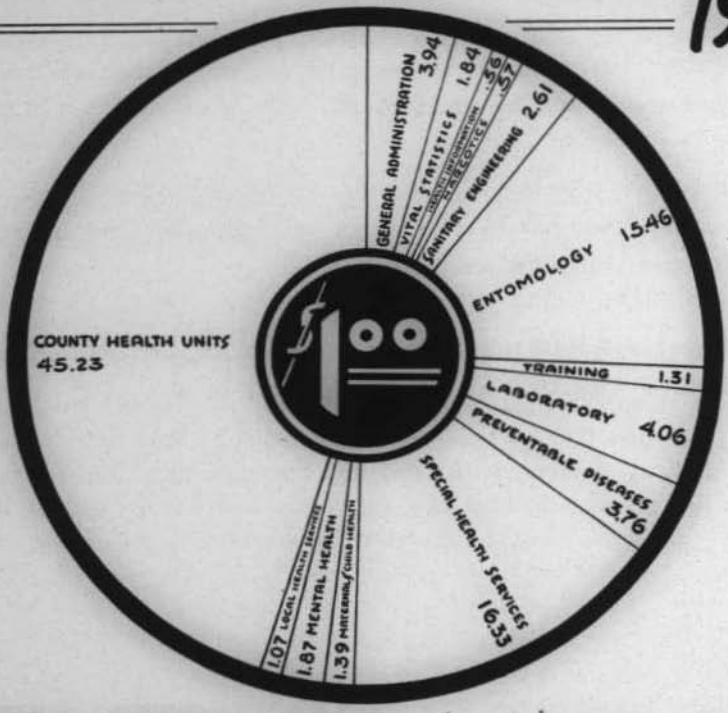
Bureau of Entomology

..... hydraulic dredges were used to place 1,428,786 yards of earth in eliminating 716 acres of mosquito breeding grounds.

..... 48.605 miles of ditching were done by machine and an additional 157.40 miles were ditched by hand while 24.4 miles of dikes were built to help eliminate other mosquito breeding grounds. Deepening, filling and grading eliminated another 315.75 acres of breeding grounds.

Bureau of Finances and Accounts

the PROPOSED BUDGET for FLORIDA STATE BOARD of HEALTH DOLLAR FOR 1958



GENERAL ADMINISTRATION	$ 544,875	3.94¢
VITAL STATISTICS	254,060	1.84
HEALTH INFORMATION	77,480	.56
NARCOTICS	79,320	.57
SANITARY ENGINEERING	361,650	2.61
ENTOMOLOGY	2,142,240	15.46
TRAINING	181,300	1.31
LABORATORY	563,100	4.06
PREVENTABLE DISEASES	521,515	3.76
SPECIAL HEALTH SERVICES	2,261,620	16.33
MATERNAL & CHILD HEALTH	192,840	1.39
MENTAL HEALTH	258,670	1.87
LOCAL HEALTH SERVICE	148,840	1.07
COUNTY HEALTH UNITS	6,265,162	45.23
TOTAL	$ 13,852,672	ONE DOLLAR

Bureau of Maternal and Child Health

..... the maternal death rate dropped from 6.4 per 10,000 live births in 1956 to 6.0 in 1957, continuing the downward trend noted for some years. The infant death rate was the same as 1956 – 31.8 per 1,000 live births.

..... nine new midwives were licensed in 1957 and an equal number were retired during the year. There were 283 midwives licensed in 1957 as compared with 299 for the previous year.

..... for the seventh consecutive year an Obstetric and Pediatric Seminar was held in Daytona Beach. Florida, Georgia, South Carolina and Alabama join forces to produce the seminar each year. This year it was attended by 401 physicians, nurses and others.

..... the special project for care of premature infants in the Premature Demonstration Center of the Jackson Memorial Hospital in Miami continued under a special grant from the Children's Bureau. There were 268 infants from Dade and surrounding counties cared for under this program in 1957.

..... a number of standard and specialized incubators were distributed to various county health departments to provide better service to premature infants. The equipment was placed in local hospitals on indefinite loan from the local health departments.

..... a series of workshops on Normal Child Growth and Development have been held in nearly all counties of the state.

..... cooperatively with the State Department of Education and a group of voluntary health agencies, the bureau carried forward a program of in-service training for school health coordinators through regional clinics.

..... audiometers and illuminated Snellen charts have been distributed to county health departments for use in their school health programs.

..... this bureau participated in the Children's Bureau special project for migrant workers. The team is now staffed with six public health nurses, a medical social worker, nutritionist, health educator, liasion worker, sanitarian, two clerks, and part-time medical consultants.

..... the television series on Child Growth and Development, presented by the acting director, has been continued.

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1217 Pearl Street or P. O. Box 210

JACKSONVILLE, FLORIDA

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Governor of Florida

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All Counties in Florida have organized county health departments, except St. Johns County

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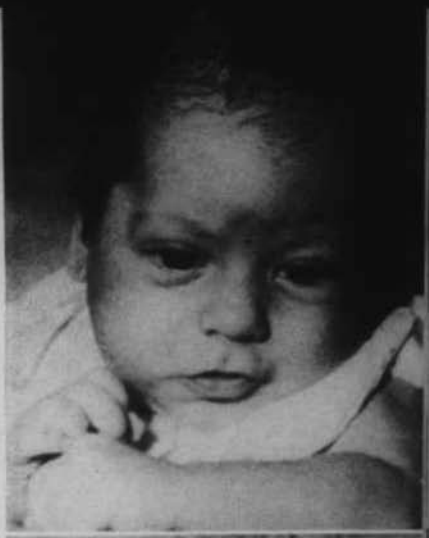
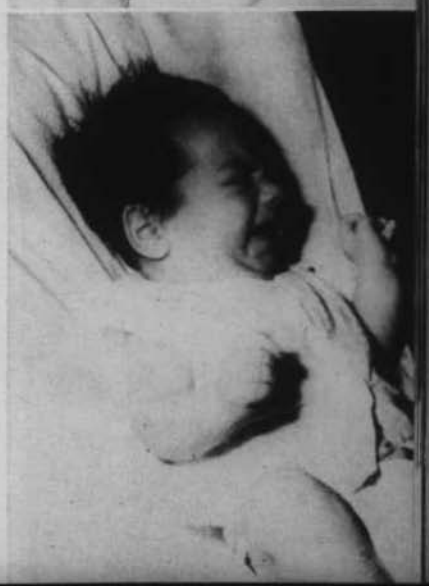
PREEMIE PROBLEMS

"PREEMIE PROBLEMS"

THE PREMATURE BABY — like death and taxes — is a problem that will probably always be with us. Although the percentage of babies born prematurely in the past twenty years has been dropping, the doctors tell us that there are certain unavoidable conditions which will occasionally occur causing a premature birth. Unfortunately, the death rate for prematures is much higher than that of full-term babies. In 1956 there were 97,320 births in Florida. During the first year of life 3,090 of these babies died, of which 1,340 were prematures. Since premature babies accounted for 43 per cent of all infant deaths the problem of how to save these lives assumes large proportions.

The picture for the entire nation was similar to that of Florida. For deaths due to prematurity, Florida re-





FLORIDA HEALTH NOTES

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corded 6.4 deaths per 1,000 live births and the United States, 5.3. Rates for the white race were: Florida 4.9 and the United States, 4.7. For the non-white races we recorded 10.2 per 1,000 live births and the United States, 8.9.

For this reason the Bureau of Maternal and Child Health of the Florida State Board of Health is much concerned about these tiny babies and is participating in a series of studies to attempt to avoid as many premature births as possible, and to better the chances of survival of those who are prematurely born. With the assistance of the Children's Bureau and the staff of Jackson Memorial Hospital in Miami, a Premature Demonstration Center was set up some years ago for the specific study of prematurity and its complications. Staffed with specialists and nurses especially trained for working with premature babies, the Center has done an outstanding job of making more knowledge and practical techniques available to others in Florida who also work with premature babies.

WHAT IS A PREMATURE BABY?

Generally speaking, any baby born before the full-term of nine months has passed is premature. The American Academy of Pediatrics, an organization of outstanding baby doctors, has set as a standard (for a full-term baby) a minimum weight of 5½ pounds at birth. Babies weighing less than this are considered to be premature and receive the same attention regardless of the number of months the child was carried by the mother before it was born.

The period the baby spends within its mother's body may be divided into three parts. The first two periods include the first 28 weeks of pregnancy. During this time the organs and tissues are forming and beginning to assume the shape of a baby. During these first 28 weeks, it is almost impossible for the child to live after it is born, for its body is not completely formed until the 28th week. Then, during the last twelve weeks, the flesh continues to grow and the baby slowly matures. At the end of 40 weeks, the baby usually enters the outside world — in short, is born. The baby may be born anytime during the last 12 weeks and still have a chance to survive — depending on many factors — and this is the premature baby.

Obviously, a baby born 12 weeks ahead of time has less chance of living than a baby born four weeks too soon. During the intervening eight weeks it has had much more time to grow and gain strength to face

the outside world. However, the baby born 12 weeks too soon does have a chance, although it may be a slim one.

From studies that have been made, it appears that the bigger the premature baby, the better chance he has.

Weight at Birth	Chance of Survival
0-2	3%
2-3	27%
3-4	60%
4-5	78%
5-5½	94%

Thus we see that the smaller the baby the greater the odds against him. Even with the larger babies there are always dangers that shadow any youngster just starting his life.

WHAT CAUSES PREMATURE BIRTH?

Pediatricians (baby doctors) have been working for years to find the answers to this question. In different reports on cases of prematurity, anywhere from 30 to 70 per cent are listed as unknown. In the rest however, they can connect some disease or injury of the mother or child with the premature birth and show how it was the cause of the trouble.

Let's look at one of the easiest causes to explain — multiple births. Twins are usually less than five pounds in weight at birth. An average normal baby usually weighs six pounds or more at birth. So if twins weighed as much as normal babies they would give the mother a lot of trouble in carrying them. Experience shows that triplets and quadruplets are never very large at birth and have to be given special treatment the same as all premature babies.

Other causes of premature birth are rarer but nonetheless important. For instance: a complication of pregnancy known as eclampsia or toxemia, where the mother's face, hands and feet may swell, her blood pressure rises dangerously and she may even go into convulsions. Statistics show that toxemia is given as the cause in 29.9 per cent of all premature births. In another complication, certain tissues and membranes within the mother's body are somehow ruptured setting off a chain of events leading to a premature birth of the baby. A mother who has had a previous birth by Caesarean section might suffer a rupture of the scar tissue left on the uterus (womb) by the previous birth. It is for this reason that mothers who have borne one child by Caesarean section are sometimes cautioned by their doctor that special care will have to be taken during future pregnancies.

Several diseases have an influence on the ability of the mother

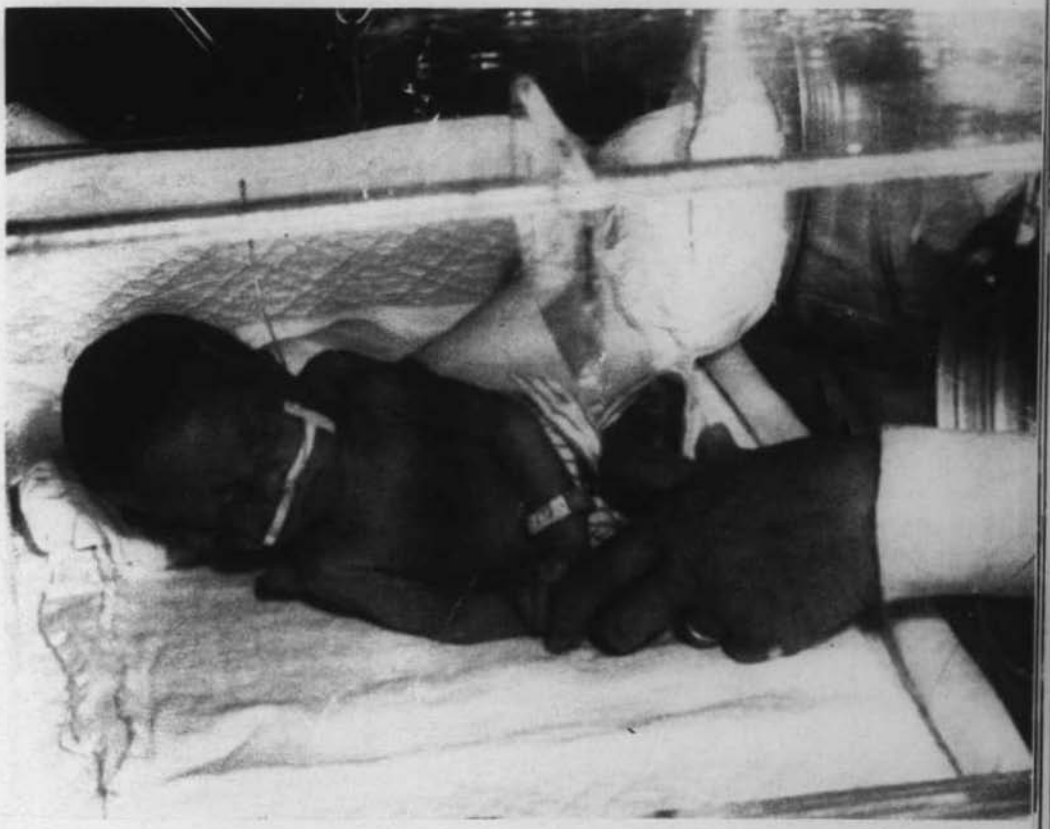
to successfully carry her baby for the full nine-month term. Syphilis, mumps, measles, chicken pox, meningitis and poliomyelitis are among these, and cancer accounts for about one premature birth out of every 2,000 pregnancies.

Malnutrition and improper diet due to poverty and poor living conditions sometimes cause premature births. On rare occasions accidents and injurious physical strain have also resulted in premature birth.

But pediatricians and obstetricians (maternity doctors) tell us that in many cases they can find no associated condition that causes the baby to be born prematurely. The search for this knowledge is endless and untiring and everyone -- nurses, doctors, technicians and public health personnel -- are working steadily to uncover these hidden causes.

"PREEMIES" ARE DIFFERENT!

Remember, these little fellows having come into the world before they should, are in a different class from the full-term baby. As soon as they arrive the pediatrician's troubles start. The biggest cause of death among "preemies" is cerebral hemorrhage. The very act of being born is difficult, not only for the mother but for the child, and the premature baby is born, usually, at a time when neither the mother nor the baby are fully prepared for it. This causes a great amount of pressure on the baby as it passes through the birth canal and the head with its pliable bone structure and incompletely formed fontanelles (openings in the top of the skull) does not always protect the baby's brain during the process. This pressure on the brain sometimes causes hemorrhaging that cannot be stopped or controlled by the doctors and in that case, the baby will soon die.



When a baby is born ahead of time, doctors have many more problems than ordinarily are encountered in a normal delivery. Certain fluids may have to be drawn from the stomach and lungs of the baby and he has to be helped to begin breathing. And right here the premature baby faces another hurdle. Sometimes the ribs are so soft and weak that the diaphragm pulls them inward instead of using this bony cage as an anchor to exert pressure on the lungs to sustain breathing. When this happens the doctors have a difficult time getting the baby's breathing started, and keeping the action going once it has been started.

It is important that the baby have sufficient warmth and oxygen. Many complicated machines have been invented to assist in this delicate operation. One used a great deal today is the "incubator." There is a rocking bed which performs very much like the larger models used for polio victims. In both these machines the baby is given oxygen in just the right proportions and the humidity of the air in the machines is kept at precisely the right level to provide needed moisture.

An incubator is used to transport the baby from the delivery room to the premature nursery. This machine provides warmth, and oxygen is delivered to the baby in one of several ways depending on the type of equipment being used.

When it is necessary to transport a premature baby from the home to the hospital or from one hospital to another an ingenious device known as a "Pragel Carrier" is used. The carrier is designed to get the baby from the home or small hospital to the incubator in the large hospital without injury. It is sometimes jokingly called a "dog box" and it does resemble the case in which pets are sometimes carried. It is a box made of aluminum about the size of a suitcase. There are several sliding doors through which the baby may be watched or cared for. Inside is an aluminum tray or cradle on which the baby lies. On all four sides of the cradle are spaces for hot water bottles. These give the heat that is necessary. A thermometer is mounted so that it can be easily read through the window. A tank of oxygen is mounted to the outside. From it a rubber tube runs through a bottle of water to a face mask inside the carrier. This is for giving the baby oxygen and increasing the water content of the air inside the case. The whole thing is light enough so a nurse can carry it easily. It is safe too since there is nothing to break. It is large enough to accommo-

date twins. The State Board of Health has given 46 of these carriers to County Health Departments.

Sometimes, when it has been necessary to give the mother quite a bit of anaesthetic, the baby has to be given drugs to offset the effects of the anesthesia.

Antibiotics, such as penicillin and streptomycin are given when an infection is present or suspected.

The first hours are ones in which the nurses and doctors watch closely for signs of anything unusual, such as the blueness that indicates lack of sufficient oxygen, or some evidence of an infection that may have been acquired unknowingly from the mother.

• CARE AND ATTENTION

Since the premature enters this world with difficulty, begins its life with difficulty and *lives* with difficulty until it reaches a reasonable size, the conclusion is that the first weeks, even months, of a premature's life are not easy ones. The care and constant attention they receive in the hospital nursery is indicative of the continuing care that often must be given when the baby is turned over to the parents.

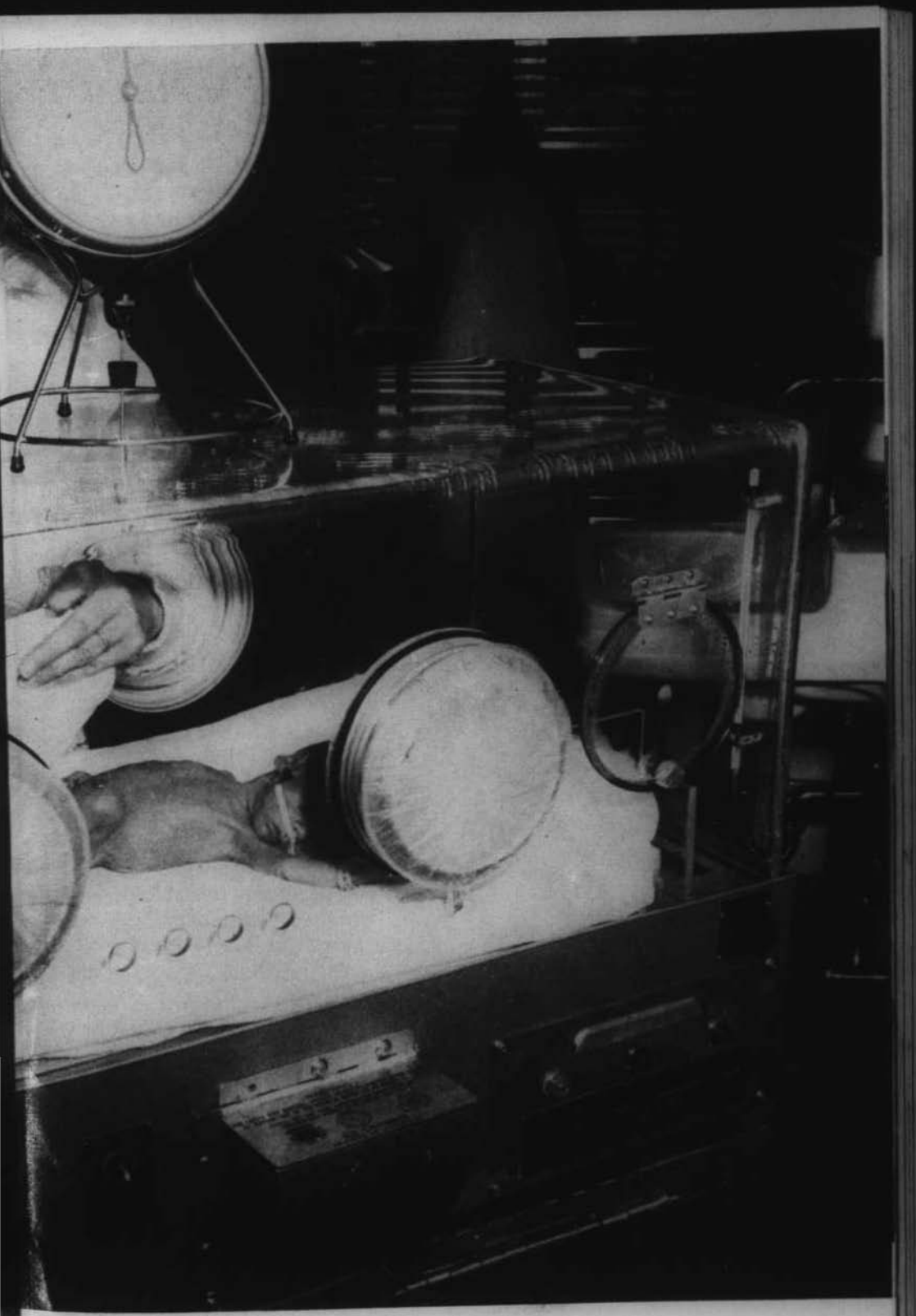
In well-run premature nurseries the nurses have to follow a rigid technique of scrubbing, wearing and changing gowns, wearing face masks, and many other details that reduce to the minimum the chance of passing

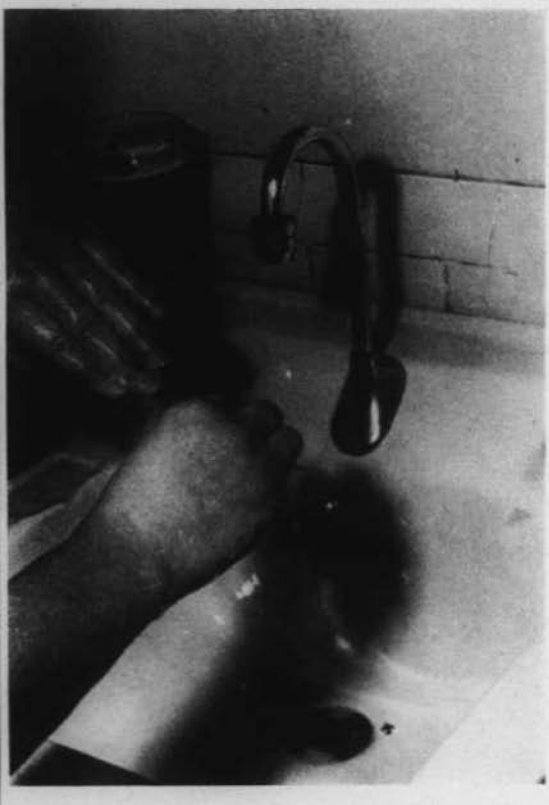
Of great importance in the care of the premature baby is the matter of the exact amount of oxygen that is included in the air inside the incubator. The level must be high enough to do an adequate job of providing oxygen for the baby but if it is allowed to reach too high a percentage for a sustained period, serious damage may result. A condition known as *retrolental fibroplasia* sometimes results from too much oxygen, causing blindness.

To prevent this unfortunate circumstance, a rigid oxygen system is followed especially in larger hospitals, whereby the nurse never uses oxygen except on orders from the doctor; a careful chart system is kept so the oxygen percentages are known to all concerned, and the nursery is equipped with an "oxygen analyzer", an intricate little instrument which measures the oxygen percentage within the incubator.

Many of the small hospitals throughout the state are not equipped with the oxygen analyzers so extra precautions must be taken. It is the hope and desire of the Bureau of Maternal and Child Health of the Florida State Board of Health that funds will soon be available to equip those hospitals currently without the analyzers.

There are a number of large hospitals in Florida which give excellent care to premature babies. It has been impossible to list them all so we have merely contented ourselves with describing the Premature Demonstration Center at Jackson Memorial Hospital at Miami; since this project is directly related to the State Board of Health. Eventually, all hospitals (and premature babies) in the state will profit from what has been learned there.





infection from one baby to another—or from the outside world into the nursery. At home it is not quite so simple to observe the same rules of cleanliness. However, there are certain basic fundamentals of cleanliness that the parents must observe with premature babies that are not particularly different from the handling of any baby.

Relatives are anxious to see the new baby "up close," having observed him through the nursery window for weeks or even months up to this time. Unwittingly they may bring dangerous germs to the baby. The constant attention to oxygen and humidity given in the hospital are now usually gone and are substituted for by the fresh air and sunshine at home. The sterile bottles and nipples used for feeding formulas prepared under strict supervision now give way perhaps to merely clean bottles, and formulas are sometimes prepared with less accuracy than that displayed by the hospital professionals.

Generally speaking, the hospital usually assures itself that the baby is ready for his venture before they release it. In some instances, a public health nurse is asked to visit the home before the baby is brought into it. Where there are several other children, the nurse determines whether any of them now have, or have recently been exposed to, contagious diseases. The general cleanliness is noted. Reporting back to the hospital, the public health nurse from the County Health Department is then advised whether the baby will be released to the parents and, if so, what suggested changes should be made (in view of her report) to insure the safety of the child at home. Some hospitals have adopted the practice of advising the County Health Department by telephone as soon as a premature has been discharged and asking the public health nurses to follow-up within 24 hours to see that all is running smoothly.

Unfortunately, there have been cases where prematures have been discharged only to return to the hospital in a matter of days with some form of intestinal infection, such as diarrhea, or a respiratory infection such as influenza or pneumonia. A case was cited at one of our largest hospitals of an infant that was carefully tended by the hospital in the premature nursery for a period of more than three months. Less than 24 hours after it was discharged the parents returned with it — dead on arrival.

It is situations such as this which make the services of the public health nurses vitally important.

If the premature happens to be the first child born to the new parents — the parents, especially the inexperienced mother, has a much bigger job on her hands than if her child had been born normally. As a leading doctor recently said, "When the baby has had to stay with us for weeks after the mother has been discharged, the family sometimes feels as if it is adopting a baby." Thus an emotional factor arises as well as physical problems. Knowing that the child has been born prematurely and has had a struggle to overcome the hazards of prematurity, the parents, who have been waiting for the time they could take their baby home, now find themselves fearing for its safety. As a result, the child receives more than usual attention, is protectively shielded from any hint of danger, and may even develop emotional problems of its own because of the attention showered by the parents. If there are other children they notice the difference in

the attention shown and sometimes feel neglected.

WHAT IS BEING DONE ABOUT PREMATURES?

In 1950 a Premature Demonstration Center was set up at Jackson Memorial Hospital in Miami. Assisted by a grant of $50,000 annually from the Children's Bureau, the center serves the Miami area and surrounding counties. The Center has been specially designed and furnished with the most modern equipment. From the beginning it has been staffed with doctors and nurses who have had special training and experience in working with premature babies. It has had a very low death rate and since its beginning, other centers have been organized in other counties, using the Jackson Memorial Center as a model.

At intervals nurses and doctors from other hospitals and clinics around the state are invited to attend week-long training courses in the techniques and procedures evolved by the Jackson Memorial staff. These courses are of great value for they make available all the facilities of the Center, including on-the-job training, as well as lectures by prominent staff doctors.

Lectures to the visiting nurses and doctors include such subjects as proper use of oxygen, scrub-up and gown technique to reduce dangers of infection, handicaps of prematurity, techniques of feeding, handling babies during the first hours of life, recognition of illness and congenital (born with) abnormalities. All the lectures are profusely illustrated with color slides so the trainees will be well qualified to recognize disorders that may appear.

If a doctor goes to the Premature Demonstration Center in Miami for special training, a nurse from his own hospital, with whom he works closely, is often sent with him. This is important for thus both receive the same training in order that there is a common understanding between them about what they have learned.

As one of the Demonstration Center staff doctors said, "We have the finest equipment available anywhere in the world today. What we need is more *trained personnel.*" The same is true at most Florida hospitals. There is plenty of fine equipment available but a shortage of personnel, especially trained to work with prematures, exists.

Through the training classes it is hoped that every hospital in Florida can reap the benefits of the work and study being performed at the Jackson Memorial Center.

Oddly enough, experience at the Center has disclosed many

interesting sidelights on the problems of premature babies. For instance, it requires a rather special type of personality to work with these babies. Nurses must have a deep desire to work in the premature nursery, with its many strict regulations. They are usually not allowed to work anywhere else in the hospital while assigned to prematures. Experience has shown that better results are obtained when nurses work with the same babies all the time. Cases on record show that there have been occasions where a nurse's simple observation on the report, "Baby does not seem to be as active as usual today," has led to immediate attention by doctors in time to ward off troubles that might have gotten a good head start before they were otherwise noticed.

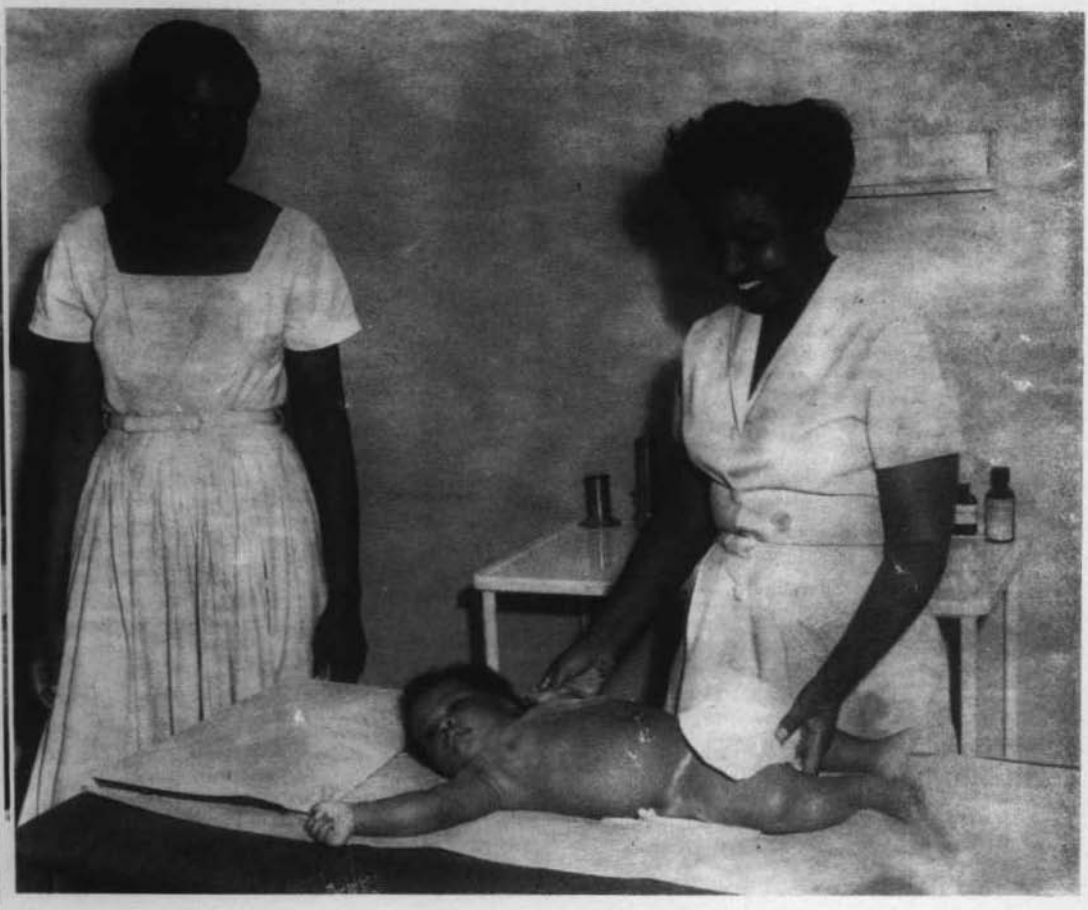
Nursery personnel take a motherly attitude toward their tiny patients and, as one of the supervising nurses observed, "We discharge our babies happy, healthy and spoiled." She is the mother of five sons herself.

When prematures are strong enough to leave the incubator and take their milk from bottles, just like some other babies, the old-fashioned rocking chair comes into use, for most modern nursery rooms are equipped with them. This is important, for the babies miss the fondling and love of their mothers for the first weeks of their lives and the nurses, rocking slowly in their chair while feeding the infants, supply this much-needed factor in the babies' lives—known as TLC (tender, loving care).

WHAT IS THE FUTURE OUTLOOK FOR THE PREMATURE BABY?

Prematures catch up with normal full-term children at a pretty fast rate once they have passed the stumbling blocks of their early life. The speed with which they catch up depends pretty much on their weight at birth. A baby that weighed between four and five pounds will be just as sound and healthy when two to three years old, and probably just as large as the average child who delivered at the end of nine months. Sometimes it takes longer for babies who had very low birth weights to catch up, but the studies of the Jackson Memorial Center personnel show that by the time the babies have reached school age you cannot tell any physical difference between them and babies who went "to term."

Therefore, if a premature birth occurs in your family and you are worried about your baby's future, try not to be too concerned over it. Discuss your baby's chances with your doctor. It is the first few months that are so all-important and which will require your constant attention



to the little details that are necessary to the proper growth and development of your child.

THE ROLE OF THE PUBLIC HEALTH NURSE

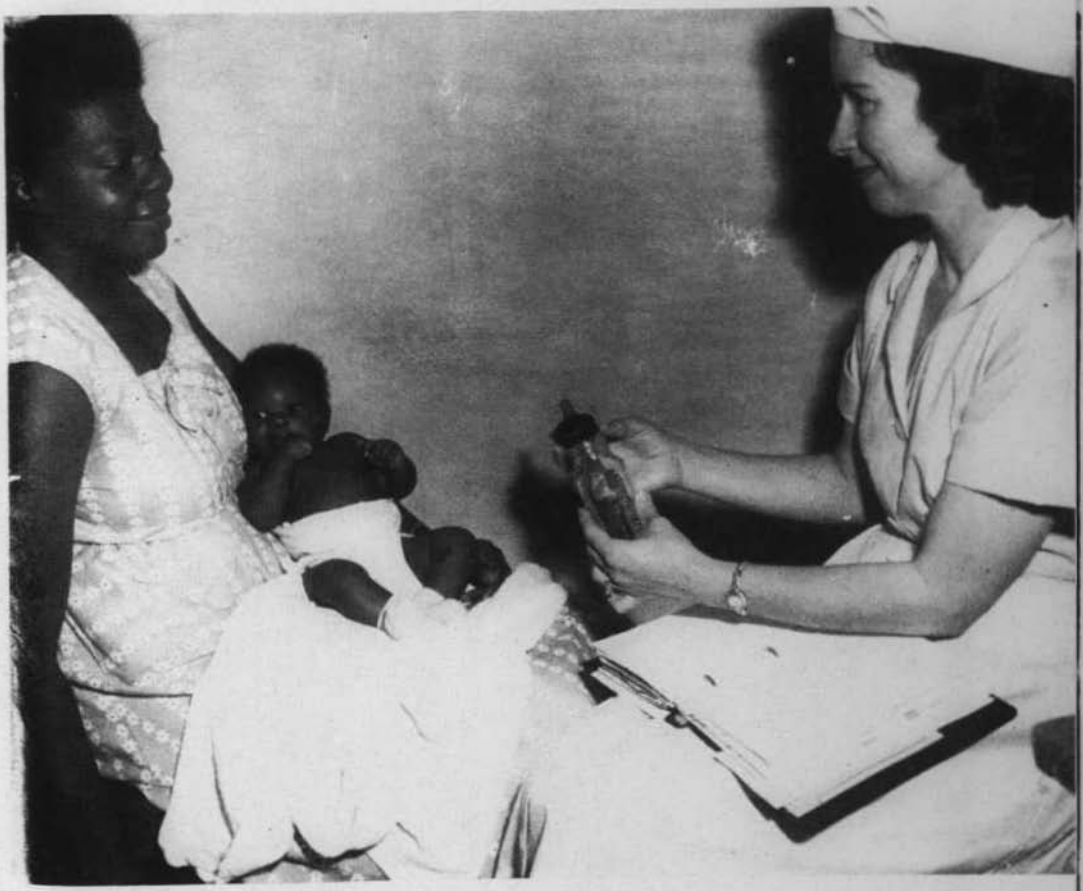
After your baby has been discharged from a premature nursery, often a public health nurse from the County Health Department will call on you, usually within twenty-four hours, to see if her services are needed. Quite often she will be able to lend assistance in teaching you how to prepare formulas, feed or care for the baby. She may call several times after this and help to interpret your doctor's orders.

The public health nurses have been high in their praise of the parents of prematures. They are very much interested in the progress of these infants for they realize the high rate of trouble among them. The parents are almost always very cooperative and this makes their job much easier. By reporting back to the hospitals and doctors they are making possible vital informa-

tion for study so that the chances of survival among prematures will grow greater with the years.

If you have had a baby in the Premature Demonstration Center at Jackson Memorial Hospital, your private pediatrician (baby doctor) who will be looking after your child when he leaves the hospital, will be furnished a complete record of the baby's physical history from the minute of birth right up until the time he was discharged. All drugs and anaesthesia used are noted, as well as any special formulae or operations that were found necessary. The cause of prematurity, if known, is also included and the Hospital encourages doctors to confer with them about any baby.

Prematures born in the future stand a better chance of survival as more and more is learned about the conditions that cause prematurity and the techniques are improved for their care after birth. Hand-in-hand, the doctor, hospital, nurse, public health nurse, the laboratory technician and the parents are working toward a brighter day for the baby who was born too soon.



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All Counties in Florida have organized county health departments, except St. Johns County

FLORIDA HEALTH NOTES published by Florida State Board of Health since 1892

These Were Once Premature Babies . . .

Would You Have Guessed It?

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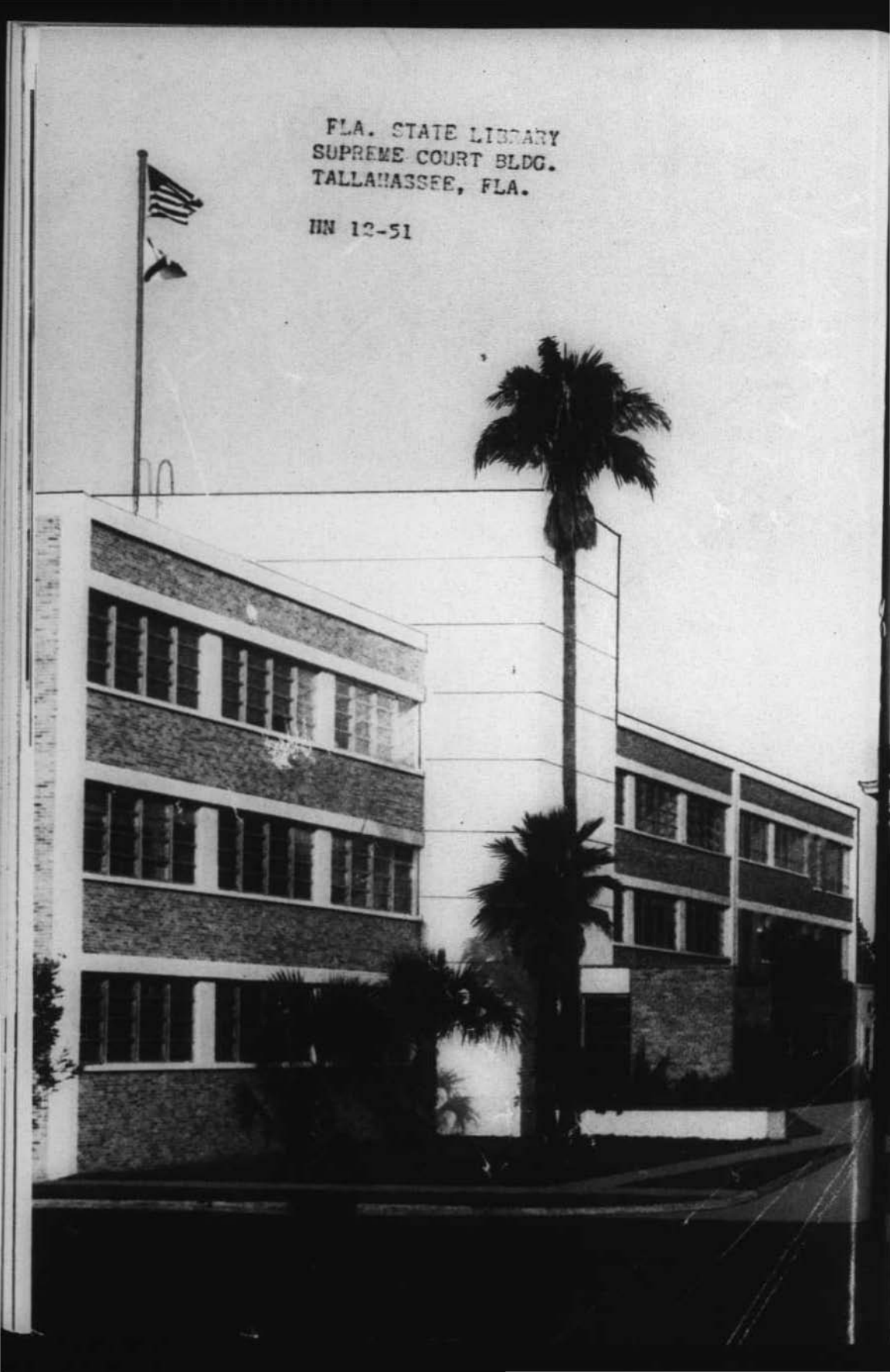


HEALTH NOTES

OCTOBER 1958
VOLUME 50 • NO. 8

THE IMMOKALEE STORY

The Immokalee Story

MIGRANTS—agricultural migrant workers—follow the "East Coast Stream" into Florida sometime between September and November and stay with us until around May or June. Then they turn around and head back "up the stream," perhaps as far as northern New York State. Picking, planting, harvesting, packing—these often homeless wanderers make a tremendous contribution to Florida's agricultural wealth.

But last winter migrants were caught in the freezes that destroyed crops and their means of livelihood. For it's no work, no pay.

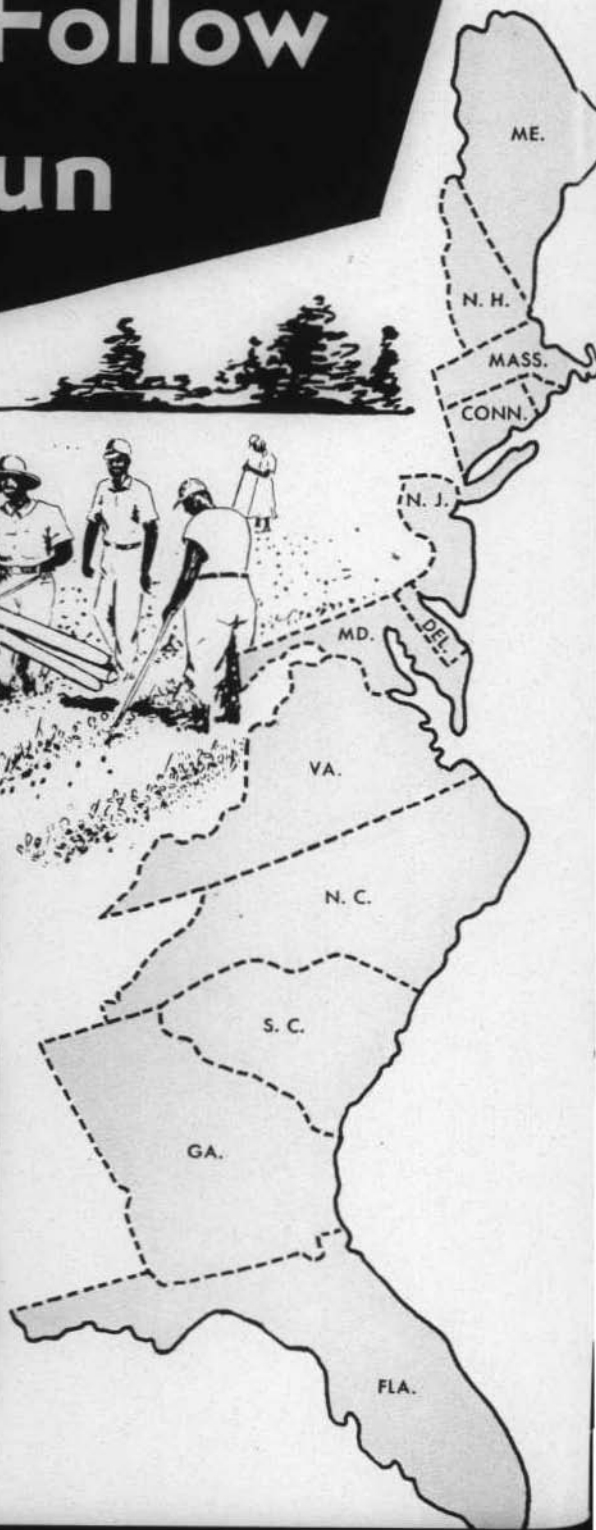
To tell the story of what happened, Florida Health Notes is herewith presenting (as a major portion of this issue of Health Notes) a talk that was given this spring to a public health organization. The authors were the State Health Officer, Dr. Wilson T. Sowder and the Director of the Lee and Collier County Health Departments, Dr. Joseph Lawrence.

Here follows an abstract of the talk, which tells better than we could, what happened to one group of migrants, during one bad season.

✚ ✚ ✚ ✚ ✚ ✚

ALL OF YOU UNDOUBTEDLY still remember that the weather this past winter was cold in many parts of the United States. We regret to report that this was also true in Florida. On two successive nights, December 13 and 14, most of the state had below freezing temperatures and in general, the weather was colder than it had been in the past forty years. As a result of this cold wave, the citrus fruit crop was severely damaged and the growing vegetable crops were wiped out. To further complicate the situation, we began to have unseasonable rains. Following the freeze the growers had very optimistically replanted their vegetable crops but the severe rains ruined these. This was a tragedy throughout the winter vegetable growing area of Florida. The extent of the financial loss resulting would be very difficult to estimate but it was tremendous. Hard times naturally resulted for most farmers and their employees. Residents of the area were thrown out of work, and to further complicate the picture, many thousands of migrants in the southern half of the state became almost completely without income and in most cases desti-

They Follow The Sun



tute. They had put nothing away for a rainy day and we did have rains. Having no savings, they became a public responsibility. While this situation existed in many counties, the problem was concentrated in four south Florida counties. We have selected, however, for our discussion today, a particular community called Immokalee and its surrounding territory. The other problem areas were located in larger and wealthier counties which were better able to handle the problem.

Immokalee is an unincorporated town with about 3000 permanent residents. It is one of the most remote and inaccessible places in the State of Florida, southwest of Lake Okeechobee and on the edge of the Everglades. It is located in Collier County, a very large county in area (2032 square miles, about twice the area of Rhode Island) but with a small population estimated at 14,000. It has an organized County Health Department, but it is part of a bi-county unit which includes adjoining Lee County with a population of 38,700. One of the authors serves as health officer for both counties. Immokalee is known as the "last frontier" in Florida and it is certainly that. It is a sleepy little farming community during most of the year, with a wide highway going down the main street and all important businesses facing it. The water table in the area is quite high, so that there was a great deal of standing water throughout the town and outside of it. It is hemmed in by large land holdings, and the Everglades and cannot expand. There are approximately 1200 houses there and of these, according to our survey, only five per cent are in good condition, ten per cent are in fair condition and about 85 per cent could be best described as shacks. There are several so-called labor camps within the town, down in the Negro quarters and most of these are in deplorable condition. Outside of the town are other camps which are not much better. There is no public water supply, no public sewage disposal system, and no garbage collection system. As stated before, the community is not incorporated and one of the very good reasons for this is that the tax levy for a municipal government would yield only an estimated few hundred dollars because of Florida's Homestead Exemption Law. Shallow wells

FLORIDA HEALTH NOTES

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are used for water supply and there are some septic tanks, a lot of privies, but many homes are without visible means of sewage disposal.

THIS SLEEPY LITTLE TOWN, at the onset of the growing season, usually lasting from October to May, takes on a different aspect. There is a sudden influx of from 5000 to 8000 migrant laborers and the population increases to about 11,000. Remember, that there are only about 1200 houses in the area for the entire population. This situation has existed in Immokalee for several years. While the headquarters of the Collier County Health Department is in Everglades City (the county seat), there is a small clinic building in Immokalee. The building is about 25 feet by 50 feet but is fairly well equipped. A new clinic building is being built with county and federal Hill-Burton funds which will be modern in all respects.

At the beginning of this year, the Collier County Health Department had the following staff: one health officer, three public health nurses, two sanitarians, two clerk-typists, one part-time clerk, one interpreter (for Spanish-speaking patients), one mental health worker. This staff was larger than it otherwise would have been because of special funds obtained from the U. S. Children's Bureau for a demonstration project in migratory labor areas and also because of special funds appropriated by the State Legislature for migratory labor health work. This staff was increased during the next few weeks by the addition of the following: one nurse, one physician on a fee basis, and one sanitarian.

The reason for the interpreter is that about five per cent of the migrants are Puerto Rican and 25 per cent are Mexican or Texan-Americans who do not speak or understand English. Before the crisis, the normal number of calls in the clinic on any given day would be from 20 to 25 persons with about 15 to 20 maternity cases being seen each week.

In spite of the two freezes in December and the rains, with the crops being wiped out twice, the growers in this area were fairly optimistic; they had replanted a third time. However, in the latter part of December, the editor of the weekly newspaper of Immokalee was approached by several migrants because they were hungry. He investigated this area and found that there were 60 to 70 families who were in dire need of warm clothing and food. Consequently on December 27, this editor sent a telegram to Governor Collins requesting what assistance he could give to alleviate the conditions in this area. On December 28, the Red Cross investigated the area and on January 2 declared it

to be a disaster area. During this time there had been no increase in the calls at the Health Department for medical or nursing services. Unfortunately, the local doctor developed infectious hepatitis on December 24 and as a result the town was without any doctor, as he was the only doctor in this area. I might add that the other two towns in Collier County and one town in Lee County are the closest towns to Immokalee. These towns are Ft. Myers, Naples and Everglades City, all of which are approximately forty miles from Immokalee.

As a result of the area being declared a disaster area, the needy residents of Immokalee had to be certified for county welfare. As they have no county welfare as such in Collier County, the County Commissioners requested that the Health Department in Immokalee function in this manner. As a result, on January 2, 3, and 4, the office was literally swamped with the people to be certified for welfare. This was soon corrected and we got help from the County Commissioners so that our nurses and clerk were freed for their normal health department work. The local churches and the Salvation Army began to feed the migrants in soup lines and food orders were given to residents.

As a result of the work of the local newspaper editor, this well publicized story (by the Miami and Tampa newspapers) reached television and radio on a national hook-up and donations of food and clothing and money began to pour into this area from all parts of Florida. Literally thousands of pounds of clothing and tons of food were sent. Several thousand dollars were sent in (in cash) and something had to be done about the arrangements for handling all of this.

There had been a migrant committee of local citizens in Immokalee some years ago. The local Methodist minister more or less inherited the chairmanship of this committee. The clothing, food and money were turned over to them to handle. They began to function immediately and set up a registration of all needy people, migrants and local people, listing the individual and his dependents. We found that migrants in this area sometimes have as many as sixteen children. It was found that quite a few migrants had left the area because of the bad conditions there, but nevertheless we had about 3500 migrants still living in Immokalee at this time. Because of the situation, we were able to obtain surplus commodities and these, along with the donated foods, were distributed by the migrant committee. The State Department of Public Welfare helped the migrant committee in setting up the registra-

tion and supervised the surplus commodity distribution. The first food distribution to migrants was made on January 9 and was continued every two weeks until the middle of April.

Because the local doctor, the only one within forty miles of the area, was ill in the hospital, arrangements were made by the County Health Department for a doctor from Fort Myers to man our clinic two mornings a week. The doctors in the towns of Naples and Fort Myers offered their services and notified us that they would be glad to take care of any hospitalized patients in their hospitals. We did not begin to get any increase in calls for Health Department services for about a week. However, at that time illness definitely began to increase with a great deal of diarrhea among infants, and obvious malnutrition among the infants and children. Remember, the housing and sanitation are very poor in this area and always have been. There was mud and water all over town.

Because of the increased load at the Health Department with this epidemic of diarrhea in children, on January 16, a U.S. Public Health Service doctor, who was assigned to the Central Office of the State Board of Health in Jacksonville, was sent to Immokalee to help out the part-time doctor from Fort Myers. From then on we had a doctor on call 24 hours a day in Immokalee until February 14 when the local physician began to work again. This resident physician whom we had during the sickness of the local doctor was easily able to handle all calls that came in and he also made home calls. At that time, the patient load was from 75 to 100 patients a day.

Because of the appeals of the local doctor and from a doctor and his wife in Naples, the Pfizer Company donated about $1500 to $2000 worth of antibiotics and Mead Johnson donated thousands of dollars worth of baby foods and vitamins for babies. In fact, Mead Johnson donated approximately 13 tons of it. This was all sent to the Health Department for use and distribution. Since we had received reports of two cases of para-typhoid in this area, we started a vigorous campaign on immunizations, particularly typhoid inoculations. We borrowed the health educator from the Palm Beach County Health Department and he instituted our campaign. He had Spanish pamphlets prepared explaining the need for the various inoculations, had these pamphlets distributed at the migrant center with their food distribution, and in the grocery stores. He also found a sound truck and this went throughout the Spanish-speaking area and the Negro

quarters urging all to come to the Health Department for innoculations. This was more successful than any of us had anticipated, and we did about 3000 complete typhoid immunizations in six weeks' time. The medical care was very highly adequate for this municipality and in fact, was much more complete and better than it had ever been before.

From the standpoint of personal health services, everything was going along very well, but because of continuing unfavorable publicity, the Governor of Florida directed the Adjutant General of the Florida National Guard and the State Health Officer to personally investigate the conditions in Immokalee and make a report to him with recommendations. Up to this time, the Collier County Health Department had handled the job on its own with advice and assistance, including consultant visits from the State Board of Health, and with some supplementation of its budget by state and allocated federal funds.

THE ADJUTANT GENERAL and the State Health Officer visited the area promptly following the Governor's order and were accompanied by the Director of the State Department of Public Welfare. The medical, nursing, sanitation, and housing conditions were investigated and interviews were held with as many of the migrant laborers as possible. All of these interviewed stated that they were getting enough to eat but not necessarily what they liked. An outstanding complaint was the lack of coffee. No one really looked hungry and there was food on the shelves in all the houses. No one was found who was in need of health services, who had not obtained them. Prior to this visit, there had been complaints about home deliveries by midwives but free hospitalization had been provided for deliveries as well as for other acute medical conditions under the state-county Indigent Hospitalization Program. This program is available to both residents and non-residents of the state.

Although food was adequate at the time of the visit, a food crisis was anticipated within a week or so because of the lack of sufficient federal surplus food commodities of the appropriate variety and kind. Housing and sanitation were found to be deplorable but it was recognized that such conditions could be found in many other places in the state, as well as throughout the South and for that matter, the North as well. These facts were presented to the Governor along with recommendations for state funds for the purchase of supplementary supplies of food. Long-term recommendations were made concerning housing and sanitation

and it was especially recommended that a municipal government be formed. In addition, the State Health Officer recommended to the Governor that $30,000 of state emergency funds be made available to the State Board of Health for a Sanitation and Clean-up Campaign. The inspection of the area by the Adjutant General and the State Health Officer took place on January 30. On February 4, the State Health Officer appeared before the Governor and the Cabinet sitting as the Budget Commission, and obtained full approval for the $30,000 fund. That body also approved a grant of $15,000 to the State Welfare Department for the purchase of food.

The health project was presented as having the following purposes:

1. To correct as far as possible poor housing and sanitary conditions.
2. To clean up the town generally.
3. To demonstrate to the residents of the community ways and means of continuing improvements.

It was, of course, pointed out that a major side benefit of the project would be the employment of many unemployed migrant laborers. The Governor and the Cabinet specifically pointed out that they had no authority to provide funds for an unemployment relief project and that such benefits that might result must necessarily be incident to the carrying on of a health project. This did not prevent the press from immediately labeling it as a "Baby WPA," although this had no particularly unfavorable effect.

The plan as submitted to the Governor and the Cabinet provided that most of the funds—80 per cent—would be used for employing laborers and that not more that 20 per cent could be used for materials and supplies. The Governor and the Cabinet were also requested to direct that all state agencies render all possible and necessary assistance to the Health Department on this project. This directive was promptly issued and it resulted in substantial assistance from the State Road Department in the form of trucks and equipment and it made an airplane available to the State Health Officer and his staff for the purpose of visiting the project which is about 300 miles distant from the State Board of Health headquarters in Jacksonville, and not easily accessible by ordinary means of transportation.

WHEN THE FUNDS for this project were provided, the State Board of Health had a choice of operating directly, or through a small county health department. The only inquiry that was made before making this decision was to inquire of the Bureau of Local

Health Service whether the experience and qualifications of the county sanitarian were adequate for the job. When it was learned that he was capable, the responsibility for the supervision and operation of the entire project was placed in the County Health Department and Dr. Lawrence was so advised by telephone within a few hours of the Budget Commission's approval of the use of the funds. As stated previously, the investigation of the situation took place on January 30. The funds became available on February 4 and the County Health Department was urged to be ready to put about 75 people to work by February 11. Strange to say, no one seemed particularly surprised when the project actually started on that day with 37 migrant workers. However, in order to prepare for the program, an entire class of sanitation trainees (from Jacksonville) were transferred to Immokalee the week before and also other state employees were sent to the area as follows: two sanitary engineers, two sanitation consultants, one clerical consultant, one nursing consultant and a foreman from the Bureau of Entomology. This was more people from the State Board of Health than the County had ever seen before! Later, a health educator, a nutritionist, and a medical social worker from a migrant labor project in a nearby county (Palm Beach) were sent to Immokalee to lend assistance. By this time the staff of the County Health Department itself had been increased so that it consisted of a full-time sanitarian, three public health nurses, a clerk, a mental health worker and an interpreter, plus the health officer. Under the plan, all employees, whether state or local worked under the direction of the county health officer.

On February 6, a meeting was held with the Collier County officials, State Board of Health, County Health Department personnel and the Immokalee Migrant Committee for planning the operation. We got a list of the unemployed people from the Migrant Committee, broke them down into family needs, using the number of children as basis for need. It was decided to rotate the work among the migrants and unemployed people using only one individual from each family to work and paying the individual $5.00 per day. We figured on spending approximately $2000 a week for 12 weeks to complete this project. The reason for $5.00 being chosen for the pay was that the farmers in the area routinely pay about $6.00 a day for labor and we did not want to make this project more acceptable to the workers so that they would wish to remain with us when the farm work began in this area. Metal

number tags were obtained for the workers to wear and it was decided to pay the workers at the end of each day as they do in the fields down here. It was anticipated only one day or possibly two days per week would be the extent of the employment in any one family. It was further decided to pay the workers in silver dollars so that the merchants in Immokalee would realize how much the migrants actually trade with them. Much to our surprise most of this money went for special groceries, gasoline and to the churches. To the best of our knowledge, none of it went into any of the juke joints for liquor. At this time, the Road Department and the Bureau of Entomology of the State Board of Health offered us trucks with drivers, shovels, picks, grass-whips, rakes, hoes, and everything else that was neccessary for this project.

On February 11, the actual operation of the project began with 37 migrant workers starting work on the clean-up of garbage and trash, ditching and residual spraying of premises. As there were families in which the woman was the only wage-earner it was decided to split our forces and have a womans' work crew directly under one of the public health nurses of the Immokalee office and a nursing consultant from Jacksonville. Therefore, on the 17th of February, the women began to work in this project and 15 female migrant laborers were put to work. The functions of the women were primarily for whitewashing unpainted houses, home care of the sick, cleaning up of yards, planting gardens, helping at the food distribution center, minding children, and any other light work which we could get for them. All heavy work was to be done by the men. We had some difficulty with the Spanish names and we would list those who were to work the next day and find that we had listed about half who were women thinking they were men and vice versa. With the aid of our interpreters, we got this problem straightened out. The sanitary engineer and the sanitation consultants got busy and obtained a map of the area in order to lay out areas to be drained, the direction of ditches and the general topography. Some of the sanitation trainees were placed as straw bosses over the workers and others were used to make a survey of the sanitation situation of the town, block by block. This was all entered on the map with all the houses listed — those in poor condition, those in fair condition, those in good condition, and the same is true of their wells and individual sewage facilities. All workers were issued identification tags each morning and would be required to turn them in at the end of the day

to get paid. This was the only way to tell the players from the spectators. Work hours were from 8:00 A.M. to 5:00 P.M. with one hour off for lunch. The workers were segregated as much as possible as to race because of the language difficulty and cultural patterns. Another interesting sidelight at this time was that we required all workers to report to the clinic for typhoid shots before coming back to work on their next assigned work day. It was felt that working and living in Immokalee these people were exposed to the threat of typhoid and this was the best chance to control the disease we would ever have. As a result, we got many of these workers properly immunized against typhoid, probably for the first time in their lives.

The nurses of the Immokalee Clinic, the nursing supervisor of Lee and Collier County Health Departments, and the nurse consultant all continued the health education work among the female workers and in the homes. It was found that many of these migrants and resident unemployed workers were hungry for health education. They welcomed an opportunity to attend classes in the evening. These have been held quite regularly ever since. When our new health clinic building is completed in Immokalee, we will have adequate facilities to continue this educational phase. Another way we were able to use the women in this project was to again hand out hand-bills all over town urging all residents to come to the health department clinic to be inoculated against typhoid and other diseases, and to keep the premises clean after the town was cleaned up. It was surprising to us and disappointing to the entire crew of supervisors that the local residents of the town failed to come in for the innoculations while the migrants and the unemployed workers did come in for them. I know the migrants have obtained more complete medical care during this time than they have ever before.

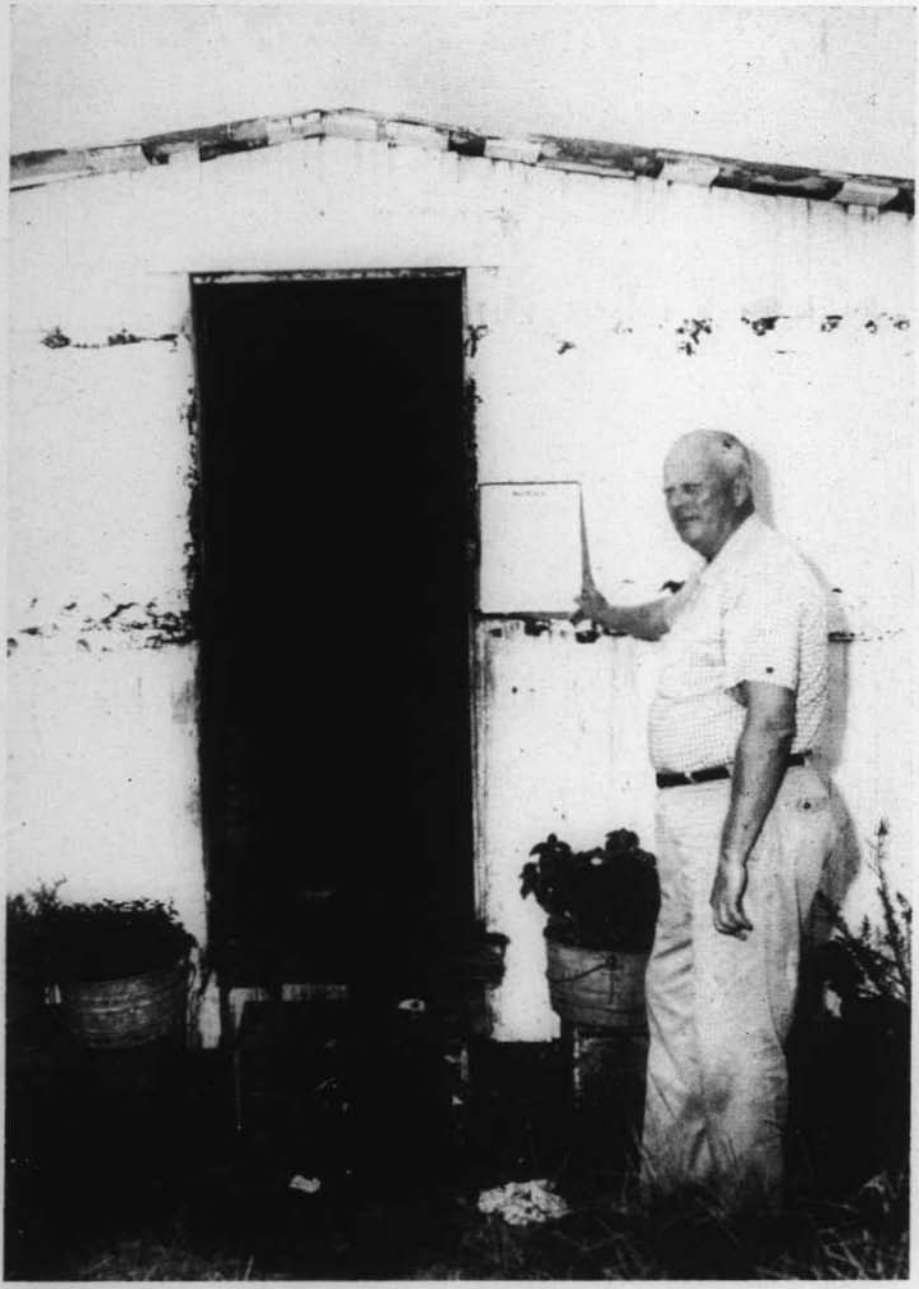
Two weeks after the project had been started, it was well enough under control and well enough planned that most of the State Board of Health employees were removed from the area. The supervisors from then on consisted of the county health officer, three public nurses, one entomologist, a sanitation consultant, a sanitary engineer and three sanitarians. The entomologist immediately began to spray all homes in the poorer sections of town and to set out traps for rats. These were quite successful and I am sure that the rat population of Immokalee has been markedly reduced as a result of this work. Work crews were set up to haul garbage, rubbish and trash from the yards

and streets in the town and about 25 truck loads of this type of rubbish were removed from the town every day for the first two months of the project. A tremendous amount of rubbish had collected in the vacant lots and in the yards of this town. Others of the project were put to work digging ditches for drainage purposes, and from 16,000 to 20,000 feet of ditching was done up to April 15. Because of this, all areas of impounded water about the town and within the town were released and drained and the town is now quite dry for the first time since the development of the community. Whether it will remain dry depends, of course, upon whether we have undue rains, and secondly, whether or not the residents and people in the area keep the ditches free of trash and rubbish.

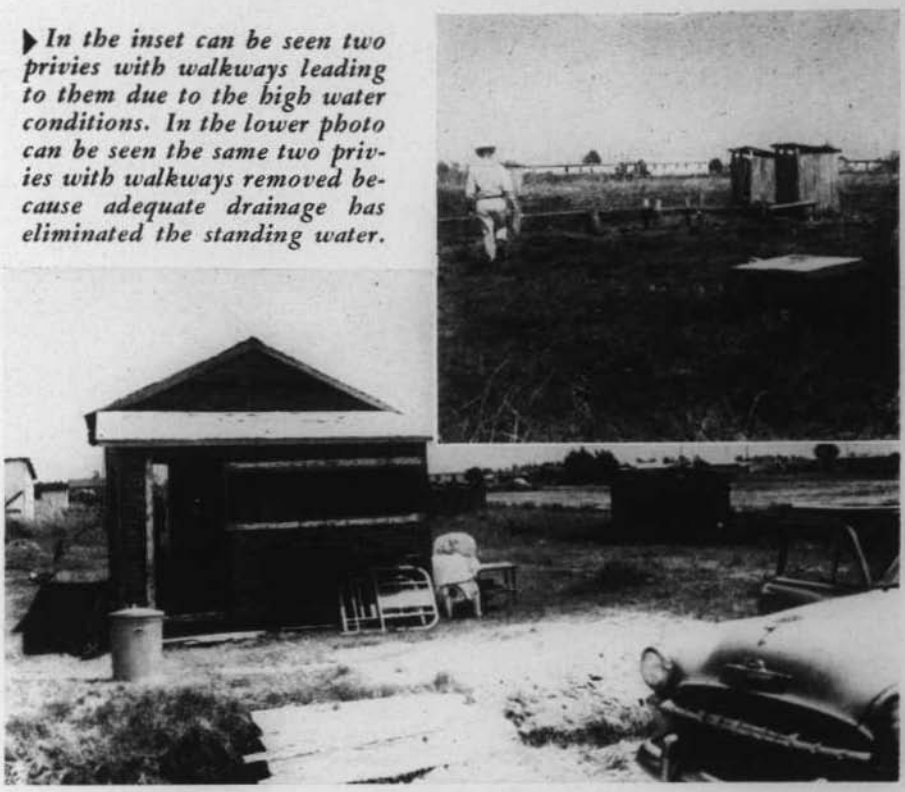
On February 13, the Governor of Florida made a surprise visit and inspection of Immokalee and expressed pleasure at the way the project was progressing, and horror at the living conditions in the town of Immokalee.

After the last heavy rains, the farmers in this area replanted a fourth time and are now beginning to harvest their crops. We have proven pretty accurate in the estimation of the time of this project, as we figured May 2 to end this work. However, in the past week it is becoming

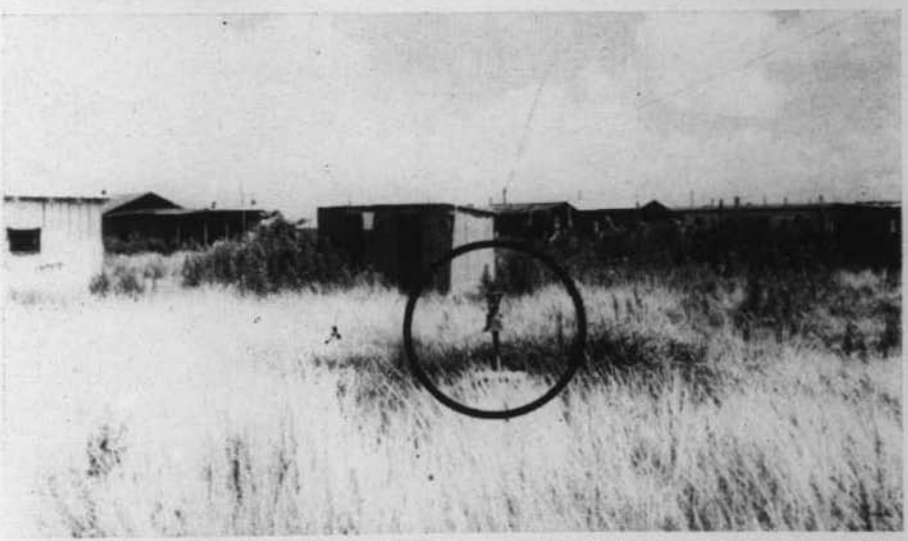
Migrants line up at food distribution hut. Foods and clothing were sent in response to a national appeal.



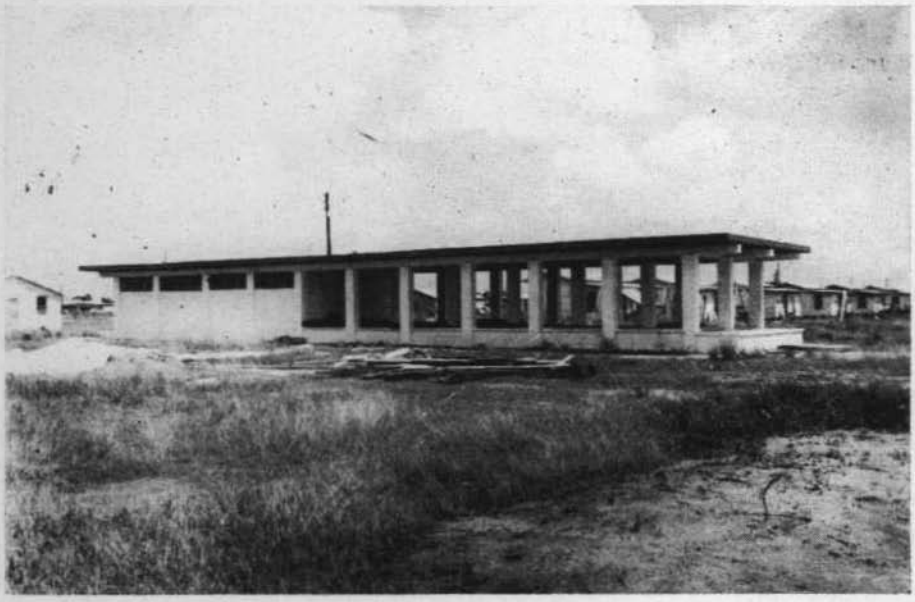
Collier County sanitarian puts up condemned sign on one of the migrant houses. More than a hundred houses were condemned due to unsanitary or unsafe conditions.



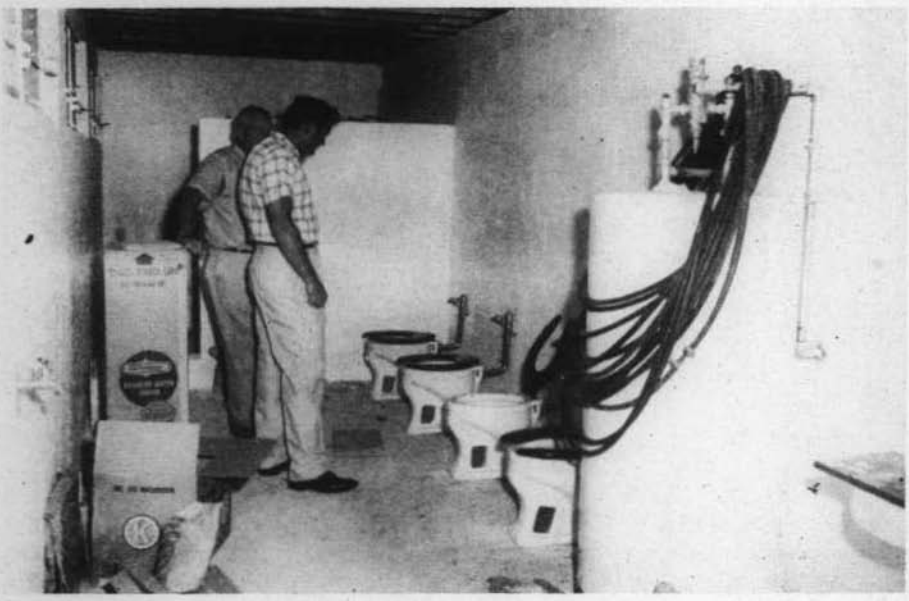
In the inset can be seen two privies with walkways leading to them due to the high water conditions. In the lower photo can be seen the same two privies with walkways removed because adequate drainage has eliminated the standing water.



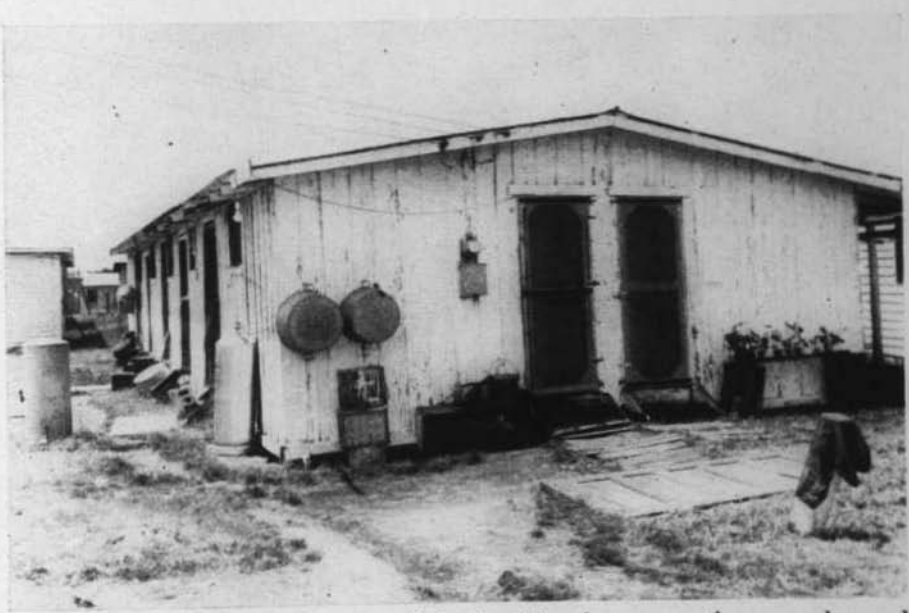
In the background condemned privies are located only 30 feet from the pump which provides several families with drinking water. Sign on door of privy indicates it has been condemned by county sanitarian.



This building, named Sowder Park in honor of the State Health Officer, was built to provide sanitary rest rooms and adequate washing facilities for the migrants. It is combined with a recreation hall for the migrant's use.



Children play on slideboard which is part of Sowder Park recreation equipment. In the background can be seen whitewashed houses of migrants.



This house, with quarters for eight families, is among those condemned for unsanitary reasons. Entrances for the various apartments can be seen on the front and side of the house.

Migrants were hired to clean up the town. Tons and tons of garbage and refuse were gathered into big piles and burned.

Several miles of ditching was done using migrant labor. The water which had been flooding the town was dispersed through these ditches and the menace of water-borne disease was reduced.

The women were given work whitewashing the houses in the migrant area. They were paid daily wages for their work.

The workers were paid daily just as they were accustomed to being paid in the fields. Here they are being paid off in silver dollars so the merchants could get an idea of what was happening to the pay the migrants received.

more and more difficult to get laborers for the project as they are reporting back to work in the fields. Nevertheless, every day we have from nine to ten people working to finish up some parts of the project which we have started and have not completed. One of the plans was to use the grounds of an old colored school as a recreational area and laundry facility. We had several dozen loads of dirt brought into the area to raise the level of the ground. We repaired swings and the sliding board and are now in the process of building a community building which will be approximately 20 feet by 80 feet and of cement block construction. This building will house separate toilet and showers for men and women, laundry facilities and an area for recreational activities. We have repaired the basketball court, resurfacing it with a black top and are building a baseball diamond.

There are many dogs always roaming the streets of Immokalee, many of which are unclaimed. As a part of the project, we constructed a dog pound and have been using the migrants as dog catchers. Any unclaimed dogs are held for three days and then sent to the Miami Humane Shelter (over 150 have already been sent). In this way we hope to control the dog population, get rid of the wild unclaimed dogs and have a much better control of the potential rabies situation. This dog pound is also incorporated in the grounds of the old colored school and will be a permanent part of the community from now on.

WHILE THE WORK on the outside has been done by the men and has been a very big benefit to the community, we feel that the work done by the women may have a more lasting value. It may have awakened the community and the working population of Immokalee to the functions of the Health Department and to the services that are offered. These people have been made more health conscious by the marvelous work done in health education. It was a surprise to all of us to see how anxious these people are for health information, and how little they know of the services that are offered by a public health department. We anticipate that the work done in this area will pay off many times in a more healthful community because of the women than the work done by the men in their ditching and trash removal. The nursing personnel did wonderful work in this field and with their weekly classes in health education, which they have now instituted, I am sure they will continue to spread health information among these very needy people. As a result of their work, many homes are clean and whitewashed, the yards are

tidy and have a much pleasanter appearance than ever before. Home gardens have been planted and yards have been beautified with flowers and shrubs. All in all, the appearance of the town has been vastly improved. How long these improvements to the physical aspects of the town will last depends a great deal upon the permanent residents of the town and the migrants. We are hoping that our instruction on the need for health and a healthful community will enable them to institute regular garbage and trash pick-up and will eventually get a community water supply. As soon as the migrants move on in the migrant stream, those houses which are unfit for human habitation will be condemned and no longer be allowed to be used.

We hope that we have not spent all of this money for the State of Florida in vain and we do not feel that we have. We think that the migrants will be a healthier crew and more aware of the services offered by the health departments not only in Immokalee but throughout Florida and the nation. We hope the local townpeople will notice the improvement and keep the areas improved. We hope that this will produce better legislation on housing, not only for migrants but for all rental housing so that sub-standard housing will no longer be allowed.

THIS IS THE IMMOKALEE STORY. We are giving it to you in order to show you how well a small, remote, and under-staffed county health department with reasonable outside assistance can handle an emergency of relatively great magnitude. We emphasize that even though outside aid was sought and received, particularly from the State Board of Health, the latter did not take immediate charge of the situation and did not need to. Also, although federal assistance was available and used, there was no special call for federal help from the county or from the state. The federal help consisted in the availability of Children's Bureau funds already provided before the emergency for health work in migrant areas; and also the availability of several young Public Health Service physicians on assignments in Florida who were detailed for short periods of time to the Immokalee Clinic during the illness of the local physician. The use of federal help was very important in the emergency but there was at no time any change in the fact that the Collier County Health Department had the primary responsibility. Of course, in the welfare field, federal surplus food commodities were of life-saving importance.

One other crisis that developed and was solved which might be mentioned before closing; the

one and only local physician upon his recovery from his illness, began to make plans to move from the community because of his poor prospects there incident to the lack of employment and money in the community. This problem was solved by putting the physician on the county health department payroll on a half-time basis until the economy of the community improved. This step helped to make up his mind to stay at his practice in Immokalee. We are hoping to be able to work out some sort of plan in the future with our hospitals and medical schools for a general practice resident to work in this area for a few months at a time. We believe that under such a program, such young physicians would learn a great deal about general practice and we believe also that such a plan would be of great benefit to this community and others with similar problems.

IN CONCLUSION, we would like to voice our pride in the manner in which a small county health unit handled a community crisis that had major health implications; we feel that this was made possible not only by the existence of a small but stable staff in the beginning but by the existence of a state-county program for the hospitalization of the indigent (resident and non-resident), a state-wide mosquito control program, and a migrant labor health program financed by both federal and state funds, and the other more usual forms of state assistance.

A FINAL NOTE

A PUBLIC HEALTH WORKER THINKS OUT LOUD:

"There is an Immokalee in every county. This particular one received a lot of publicity which brought it to the public notice, but actually there were other migrant camps that had their share of suffering also.

The big problem is that most people are taught from childhood that to be a good citizen a man should select a trade or profession, study hard, work up from the bottom, take an active part in civic affairs, buy a home—in other words, build for an element of permanency and security.

"Because migrants do none of these things, they are automatically condemned by people who have never seen a migrant worker. Remember, the migrant is important to the economy of Florida, as well as other states. Take the migrant laborer out of Florida and the farmers, particularly in South Florida, will suffer severely from a labor shortage."

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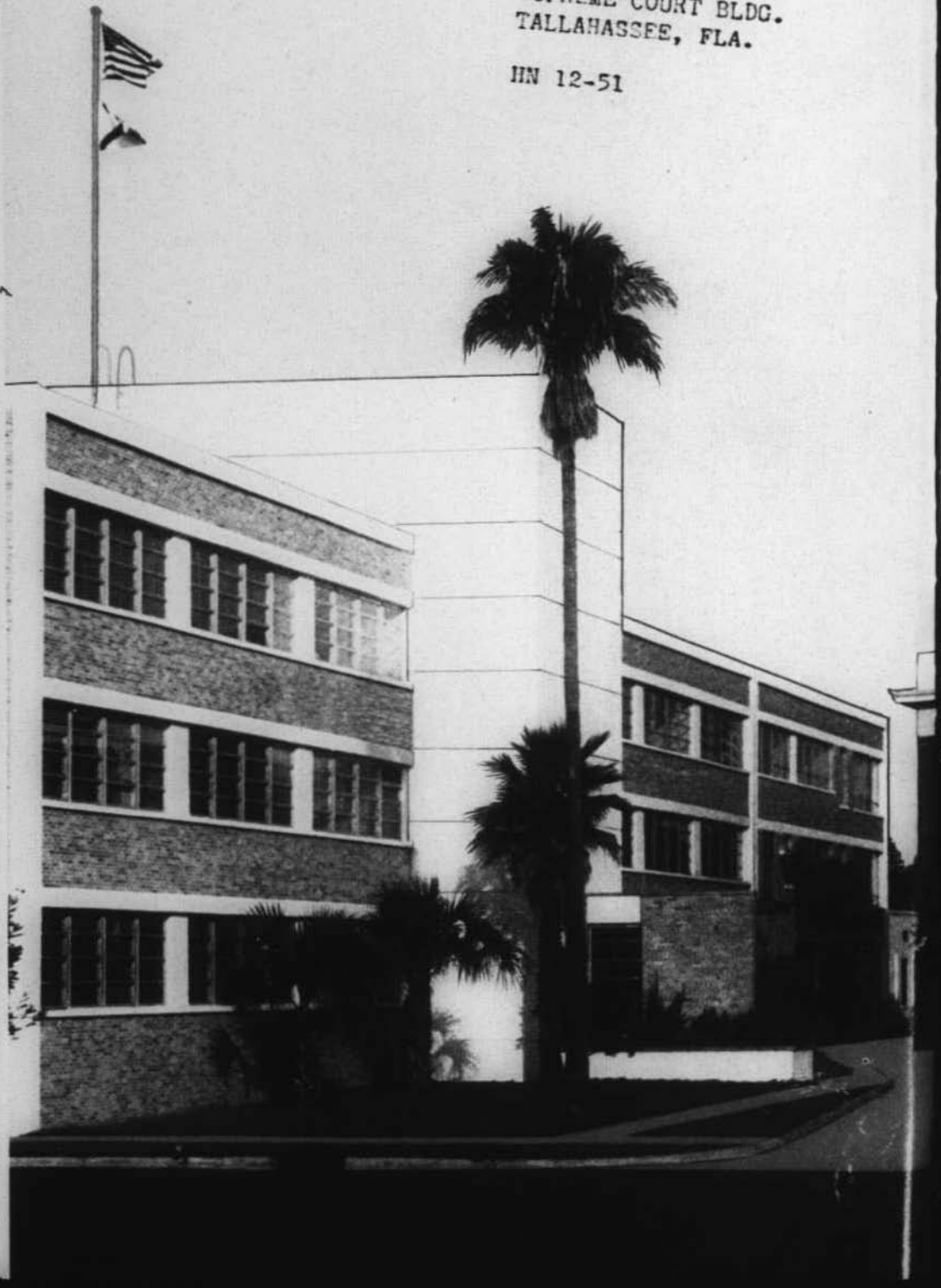
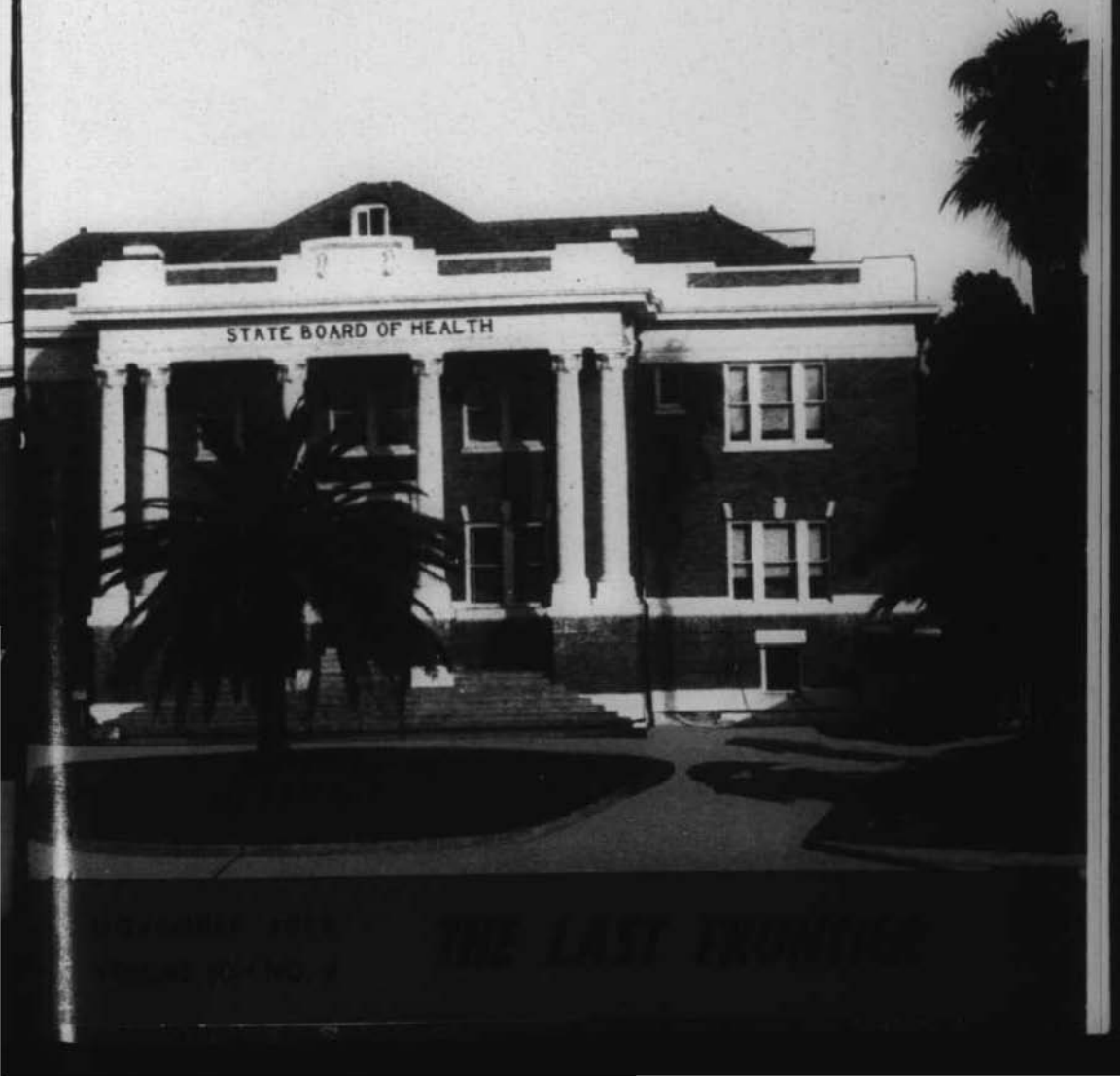
All Counties in Florida have organized county health departments, except St. Johns County

LORIDA HEALTH NOTES published by Florida State Board of Health since 1892



Florida HEALTH NOTES



The LAST FRONTIER

FLORIDA SPENDS ANNUALLY some *five and a half million dollars* on trying to find, treat and follow up persons with *tuberculosis*. The case-finding programs and hospitalization of the infected persons make tuberculosis one of Florida's most expensive diseases. But not in money alone do our people feel the pinch of this scourge. The many months of unemployment, illness and disruption of family life create in many instances a situation which calls for the best efforts of health, welfare, religious and other organizations which act in our behalf when we, the citizens of Florida, become for a time—and in a very literal way—our brother's keeper.

Tuberculosis — the white plague — the slow killer that causes two thirds of all deaths from infectious disease in the world today—is still one of Florida's major health problems. While the great virulent fevers retreated before the onslaught of modern medicine, tuberculosis, the insidious, creeping waster of man, stalked front and center to stand as one of the world's—and Florida's—greatest health enemies.

A small amount of tuberculin is injected under the skin of the forearm. Three days later the doctor "reads" the test. If a red spot has formed (positive reaction) as shown here, a chest x-ray is then ordered.

Close to 1500 people are in our state tuberculosis hospitals at this very moment. Nearly 5000 have been discharged as cured or improved since 1953. But—an estimated 5000 others—active cases — are walking our streets and fields, unknowingly spreading, in the pure air of Florida, the *tubercle bacilli* that bring upon mankind the slow, wasting killer —tuberculosis.

WHAT IT IS

Tuberculosis, a sub-acute congestive infection of the lungs and upper respiratory system, can also attack parts of the human body such as bones, kidney and other organs. In medical terminology "-osis" means "condition," and tuberculosis is a condition created in human tissue when the *tubercle bacillus* invades the body and is met by the defensive mechanism which nature has provided for the body's protection.

The Doctor Reads a

Tuberculin Skin Test

The tuberculin test is simple and inexpensive. It can be used for all school age children instead of x-rays. Here we see tuberculin being injected just under the skin of this youngster as the others await their turn. A positive reaction indicates the existence of TB germs in the body but does not necessarily mean the lungs have been attacked. Positive reactions are followed by a chest x-ray.

The bacillus, or germ, is primarily an air-borne organism, and enters the body usually through the mouth or nose. It settles in the lung passages and the digestive tract and multiplies, while its presence triggers the defensive efforts of the body to set up a group of cells, called a "tubercle," around the invader. Millions of the tubercles are usually present in a tuberculosis lesion (spot). There are no visible symptoms during the early stage. Indeed, if the patient has a rugged constitution, and the invasion is sufficiently weak, the disease may never develop further. Hence we have thousands of people whose X-rays show "spots on the lungs," but who do not have active tuberculosis. These spots are souvenirs of a successful fight against an invasion of tuberculosis germs.

But for the less strong and less fortunate, tuberculosis is not defeated so easily. For them the battle continues. The tubercles in their lungs continue to multiply, congestion occurs, the patient develops a toxic condition, and the inroads of the disease show in its effects on the person's general health. Sometimes, unless medical help is forthcoming, the tubercles will degenerate and decompose, turning into abscesses. The patient will spit blood and pus, cough a great deal, become more and more emaciated, and die in a few months of what the world, until recent years, called "consumption" — the body consumed by the disease.

THE GREEKS HAD A WORD FOR IT

Phthisis (pronounced *thigh-sis*) was the old word for tuberculosis. It meant "loss of weight." Hippocrates' students were given a description of advanced tuberculosis that stands as a classic to this day. Thousands of years before that the Brahmins of North India, forefathers of the Aryan race, chanted "O Fever, with thy Brother Consumption, with thy Sister Cough, go to the people below." The reaction of the people below was not recorded. Roman and Greek philosopher-physicians for the most part advised good food, clean surroundings and dry, cool air, for experience had taught them that these things would allow a few of their strongest patients to survive phthisis. Both the Chinese, who wasted

FLORIDA HEALTH NOTES

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away with "lao ting," and the American Indians knew tuberculosis, and treated it in the same way.

As time rolled on, more and more was found out about the disease. Early observers noted that it was most rampant under conditions of crowding, malnutrition and filth. The dark skinned races seemed to be more susceptible, all other things being equal. But people accustomed to a life in the open fell easy prey to the disease when brought to live in the crowded cities, no matter what their race.

BACKGROUND

The first hospital for tuberculosis sufferers was a building in Rheims, France in 1645, where merciful care was given to hopeless patients in the name of the hospital's patron, St. Marcoul. By 1700 physicians had learned to diagnose the disease before ulceration and blood spitting had developed, thus enabling them to prescribe the usual good food and fresh dry air earlier in the course of the disease. By then many cities in Europe had passed laws making isolation of patients mandatory, and calling for the burning of their close personal effects and clothing upon their death. But it was in 1819 that the great French physician Laennec made the first stethoscope with his own hands, and the first step toward accurately diagnosing tuberculosis was made.

EARLY DAYS

In 1893, the records show that 35 per cent of all deaths due to infectious diseases in Florida were caused by "consumption." This caused no great alarm, but forward-looking physicians were thinking of the day when something definite could be done to arrest the disease. That the disease was even at that late date considered more or less incurable is shown by the fact that one prominent physician in 1916 opposed the construction of a state sanatorium on the grounds that it would "do no good."

CAUSES OF MORTALITY IN 1892 (YEAR'S TOTAL)
27 Counties Reporting
Population - 293,670

Consumption	303
Malaria	172
Pneumonia	156
Typhoid	133
Heart Disease	130
Cholera	119

But the people were beginning to realize that something should —indeed must—be done. In 1908 a committee in Jacksonville met to discuss the feasibility of a "campaign against tuberculosis." From this committee came the Duval Anti-Tuberculosis Society, which proposed to the legislature that a law be passed to tighten sanitary regulations. Street sweepers were told to wet the streets before using their brooms. Green

grocers were required to screen vegetables from flies. Cards were printed and posted in the "poorer sections of Jacksonville" advising citizens to clean up their premises and help fight tuberculosis.

By 1916 Hillsborough County had formed an anti-tuberculosis society, and Dade County soon followed. In Duval the Society, prospering from the sale of Christmas seals, decided to hire one white nurse and one colored nurse at the combined salaries of $165 a month.

The Florida Anti-Tuberculosis Association was formed in 1916, but with the disruption of activities by World War I, not too much was accomplished at first. Months went by without any meetings being held. County and state associations quarreled over the division of funds. But on the brighter side, Dr. Ellen Lowell Stevens, head of the Health Department of the Florida Federation of Womens' Clubs, was doing a magnificent job establishing the Modern Health Crusade among the school children.

The state government lagged well behind the voluntary organizations in backing any specific efforts against tuberculosis. But in 1919 the State Board of Health voted to devote not more than $500 a month to the cause. It was not until 1927, however, that the State Tuberculosis Board was created with powers to look into the establishing of a state tuberculosis hospital. Then the Florida real estate boom and crash came along, followed by a national depression, and so it was not until 1938 that the first hospital was built in Orlando, with a capacity of 400 beds.

In the meantime, the county voluntary societies had gotten their "Itinerant Clinics" on the road as early as 1921. The Duval Sanatorium, authorized in that year, was changed into a general hospital in 1923 and became the nucleus of the Duval Medical Center of today, but not without opposition from those who thought the county should have a place just for tubercular patients.

IN THE 1920's, when the State Board of Health and the Florida Tuberculosis and Health Association were trying to introduce "traveling chest clinics" throughout the state, one of our larger cities at first declined. Finally, however, reason prevailed and a clinic was scheduled. One of the first cases discovered was the chef at the most popular country club in town. There was a rush to private physicians for X-rays.

TODAY

Today the situation is vastly different. Four modern tuberculosis hospitals at Orlando, Tampa, Lantana and Tallahassee, with a total of 1850 beds, and stocks of dramatic new medicines

are caring for many of the state's tuberculosis patients. The State Board of Health has a Division of Tuberculosis Control in the Bureau of Preventable Diseases. Mobile X-ray units with trained crews ply the state continuously in search of new cases. Educational campaigns are carried on in schools and among civic clubs and PTA groups. And so the great white plague is slowly being driven from Florida by a combination of efforts of the State Board of Health, the State Tuberculosis Board, and the 66 County Health Departments and the Florida Tuberculosis and Health Association and its county organizations.

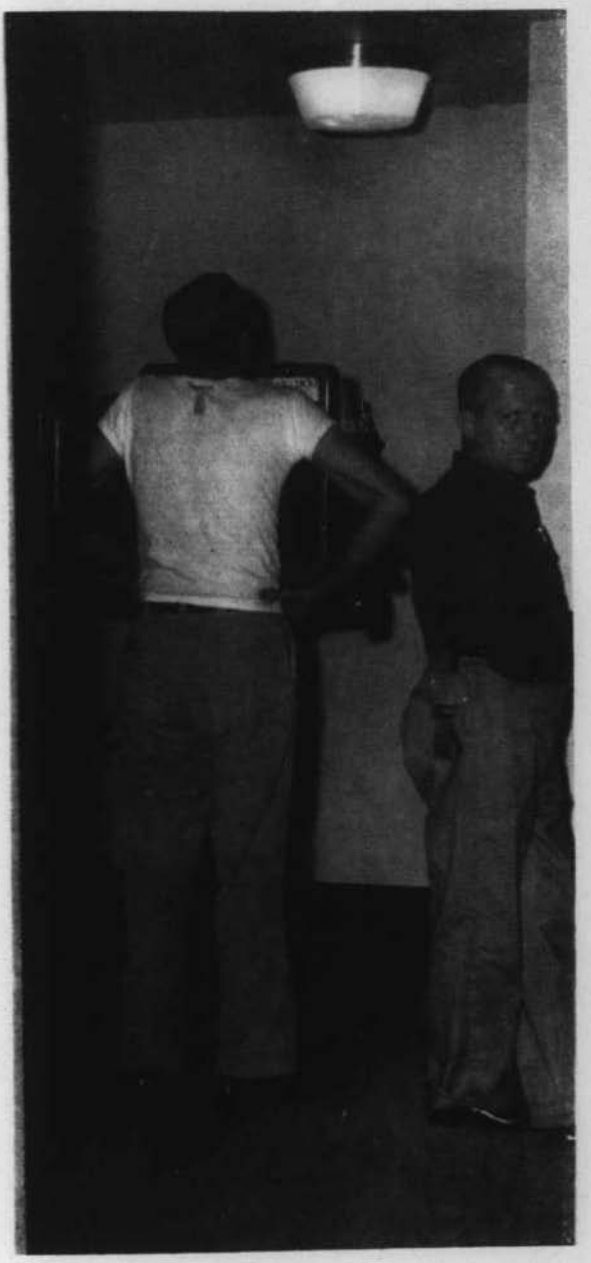
PREVALENCE

Florida is relatively free from tuberculosis — but only when compared with certain other parts of the world. The World Health Organization says three-fourths of all deaths from infectious diseases after age 15, in the underdeveloped countries, are caused by tuberculosis. Worldwide tuberculosis causes more deaths than all other infectious diseases combined. One person in three carries tuberculosis germs in his body, and one in thirty is an active case daily spreading infection to others. "Alarming" is the word the WHO uses to describe the global tuberculosis situation.

In Florida health authorities estimate there are some three or four thousand active cases. Many of these are not known, do not know they have tuberculosis, and are not being treated. Add these to the two thousand or so in hospitals and the same number undergoing treatment at home, and you can get a picture of Florida's situation.

But these active, unknown cases are not spread evenly over the state. The Bureau of Preventable Diseases suspects they are to be found somewhat concentrated in isolated pockets in rural and slum areas. The problem of bringing them to light is one of Florida's greatest—if not the greatest — challenges to be met in the next few years.

But there are other problems. Some involve things that the general public can do something about. One distressing problem, for which there is no ready answer, is that of the patient who leaves the hospital while still an "active" or "probably active" case. In the past two years 1210 or a full one-third of all patients released were in this category. Patients are not prisoners. They are free citizens, and the pressures of long confinement—boredom, false sense of well-being, desperation over family problems, discouragement — cause a few to leave the hospital still infectious, to spread the disease among their families and in their communities and perhaps meet an early death. What to do about



When prisoners are admitted to the Duval County jail they are immediately placed before this x-ray unit. A similar unit has been installed in the City of Miami jail.

This is one of the steps being taken to x-ray those people who ordinarily would not come forward voluntarily for a TB test. Other citizens not usually x-rayed voluntarily include many who rarely have the opportunity for visiting their county health departments or one of the mobile units as they go through the state. They are the rural dwellers, the aged, the homeless and others of a similar station in life.

Unfortunately, there are still those who because of superstition, reluctance or religious reasons object to being x-rayed. These people must be encouraged to come forth so they will not remain a reservoir of tuberculosis in the state.

these people has taxed the best minds in the state tuberculosis program. If there is an answer it probably lies in additional help from welfare and religious organizations which can and do work to ease these burdens that lie so heavily on the patients' hearts.

A Drastic Cure

Here is the way John Locke, the eighteenth century philosopher, reported a case of tuberculosis:

Mr. Lawrence, Dr. Sydenham's nephew, after a fever fell into a cough & other signs of an incipient Phthisis, (tuberculosis)—the morbific matter being violently translated in upon his lungs—& at length the diarrhoea colliquative came on: then ye Doctor sent him into ye Country on Horseback, (tho he was soe weak yt he could hardly walk) & ordered him to ride 6 or 7 miles ye first day, (which he did) & to encrease dayly his journey as he shd be able, until he had rid 150 miles: when he had travelld half ye way his diarrhoea stopt, & at last he came to ye end of his journey & was pretty well (at least somewhat better) & had a good appetite: but when he had staid at his Sister's house some 4 or 5 days his diarrhoea came on again; the Doctor had ordered him not to stay above 2 days at most; for if they stay before they are recovered this spoils all again; & therefore he betook himself to his riding again, & in 4 days he came to London again perfectly cured. The same course hath ye Doctor put others upon, especially in Pulmonick Diseases, & with ye like success when all things else had failed him.

The other problem with which the public need concern itself deeply is that of the broadening of the case-finding program. Florida's program—mainly the mass chest X-ray campaigns conducted over a period of years in all communities—has been eminently successful *among the people it touched*. But in a given community rarely as many as 60 per cent of the adults were examined.

But what of those not X-rayed? Their situation, and that of their families, is often the same as though Florida had never done anything at all about tuberculosis. Unless their tuberculosis has been diagnosed because they become acutely ill or it was accidentally discovered some other way, they still suffer from their disease and spread its germs among family and friends as though nothing had been done to offer them help.

Who are these people who have never been X-rayed? Some of them may be persons only you can reach. They are the unknowing, the superstitious, the unwilling, the reluctant. Skid Row characters and those objecting for religious reasons — of both races. They have never responded to the call of a voluntary chest X-ray campaign, and authorities believe they never will. They are

the grandmother or grandfather who was never accustomed to mass health campaigns and "don't believe in such things," the domestic worker, the yard man, the laborer, the isolated rural dweller. It may be that you have contact with, and have the confidence of, some of these people. Encourage them to have X-rays. Explain that there are no symptoms of tuberculosis in the beginning and that only the X-ray can tell the true story.

ATTACKS

This same problem is being tackled in official circles. Raiford Prison and the Duval and City of Miami jails now X-ray all newly admitted prisoners. They are finding cases no other method or agency would ever locate. Other counties expect to follow their example. Large businesses are being requested to examine their employees through an X-ray campaign at the plant. Schools are teaching the children that their parents and relatives have nothing to fear from an X-ray examination. The case-finding program is being broadened to hunt "high suspect" groups. For here for the next few years, is Florida's last frontier in the fight against tuberculosis, the reservoir of the disease.

TUBERCULIN TEST

The chest X-ray, about which most people know, is the major test, but not the only one used in the case-finding program. The *tuberculin test* is being used more and more, especially among school children. A positive reaction to the tuberculin test does *not* indicate the presence of tuberculous disease. If a positive reaction results from it, the tuberculin test indicates the presence of tuberculosis *germs*. This is called a tuberculous infection. Only a small minority of those persons who show positive to the tuberculin test have, or ever develop, tuberculosis. But anyone who has a positive report should have a chest X-ray immediately, to determine whether the disease is present along with the germs, and be X-rayed annually thereafter.

The tuberculin test is reliable, simple and inexpensive. A small amount of a solution called tuberculin is injected just under the outer layer of skin, usually on the forearm. Two to four days later a nurse or physician examines the site of the injection, and is able from the condition of the skin—redness and swelling—to determine whether the subject is positive; that is, whether there are tuberculosis germs in the body. If found to be positive, the subject is then considered possibly suspect, and is X-rayed to see if tuberculosis is present. The primary significance of the tuberculin testing program, especially when used on a younger school age group, is that it re-

SOUTHEAST FLORIDA TUBERCULOSIS HOSPITAL
Lantana, Florida

FLORIDA'S TUBERCUL

Although the State Tuberculosis Board was created in 1927 to see not until 1938 that the first hospital was built at Orlando with a capa hospitals with a total of 1850 beds, located at Tampa, Lantana and Ta

These institutions are caring for many of Florida's tubercular pati the period of time needed to arrest the dread disease.

SOUTHWEST FLORIDA TUBERCULOSIS HOSPITAL
Tampa, Florida

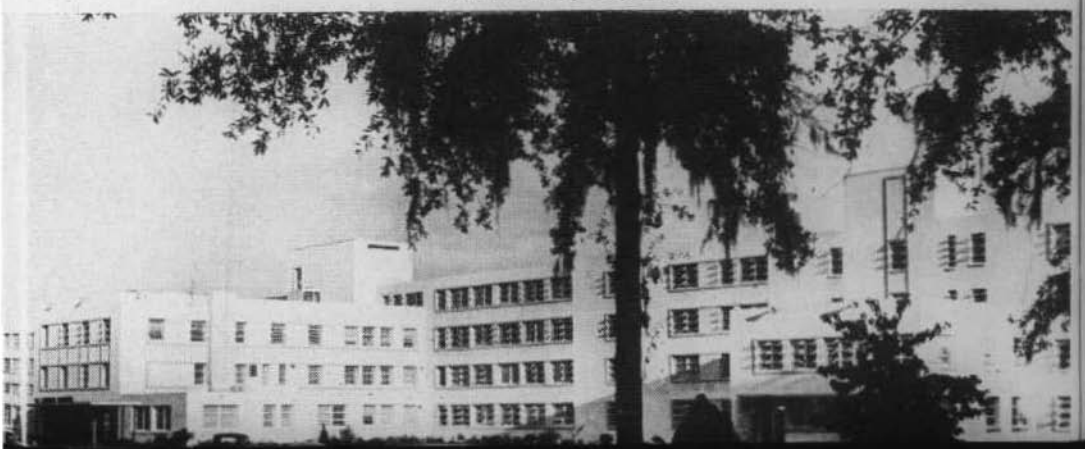
CENTRAL FLORIDA TUBERCULOSIS HOSPITAL
Orlando, Florida

LOSIS HOSPITALS

eek establishment of a tuberculosis hospital in the state, it was
pacity of 400 beds. Today there are four modern tuberculosis
Tallahassee in addition to the Orlando hospital.

atients and are stocked with dramatic new drugs which reduce

W. T. EDWARDS TUBERCULOSIS HOSPITAL
Tallahassee, Florida



A BURR COTTAGE

IN THE EARLY THIRTIES, before the state hospitals were built, isolation of tuberculosis patients was a problem. A Dr. Burr suggested tiny cottages in the back yard, half walled and half screened. A door at the rear gave entrance to the patient's own private privy. Some unique ideas cropped up during the period. One family turned the cottage into a smoke house after the patient had passed on. In another instance the public health nurse found the tuberculous mother enjoying the use of the family house while the four youngsters were locked in the Burr cottage. The doctor had told her she needed rest.

veals whether the subject has lived or is living in what we might call a "tuberculous environment"—a situation where a parent or other close and frequent contact might be infecting the child with tuberculosis germs. If such a situation is found, the contact can usually be brought to light, and treatment started.

Tuberculin testing is cheaper than the mass X-ray campaigns, and is expected to come into greater use as the declining case rates make the X-ray too expensive to use for the number of cases found.

HOSPITALS

Hospitals for the tuberculous were late in coming to Florida. Long after states with cool, dry mountain air had established many sanatoria, both private and state operated, Florida had none. The climate was considered unsuitable, and patients either went to the mountains or the desert for treatment or did the best they could in the wards or rooms allocated to the disease in county hospitals. Many had to wait at home for the slow death of the white plague.

The State Tuberculosis Board, formed just as the depression began, was greatly hampered by lack of funds, and did not open its first state hospital until 1938. This was the Central Florida Tuberculosis Hospital in Orlando. It had 400 beds, but they were soon filled and the need for more facilities was strongly felt. Then the second World War intervened, and the case-finding program — small as it was in those days—lagged, along with interest in spending money for new hospitals.

After the war, interest was quickly revived by the Florida Tuberculosis and Health Association and the state took over two former armed forces hospitals. Then the hospital at Lantana was built in 1950 with 500 beds. The one in Tampa was commissioned in 1951 with 550 beds. Still another, located in Tallahassee, and named for W. T. Edwards, former chairman of the State Tuberculosis Board, was finished in 1952.

These hospitals were quickly filled, and more would have had to be built were it not for the fact that new drugs and techniques began to shorten the stay of patients, making it possible for more to be handled in a shorter period of time. The state now has 1850 tuberculosis hospital beds, each used for an average of about ten months for one patient. If the present trend continues, no additional hospitals or beds will have to be provided.

TREATMENT

Tuberculosis is not *cured* as in the case of most diseases. Tuberculosis is inactivated. This means that with proper care and treatment the course of the disease can be stopped. But, often the

damage remains and to some extent the germ remains, and the patient must always guard against relapse. He does this with rest and medicine for the most part. He can become an inactive case and cease to spread the germs, but he is never cured—not as we ordinarily use the word.

As we have seen, the ancients discovered that a victim of tuberculosis could sometimes rid himself of the symptoms of the disease with good food and proper treatment. These were the rare exceptions, however, and only in very recent years—in fact, since World War II—has there been much of a change in the treatment of tuberculosis. Now the cold sleeping porch of the old sanatorium is gone. The "collapsed lung" — pneumothorax treatment—is no longer used, and the average patient is released as inactive much sooner.

Streptomycin is partly responsible for this change. This "wonder drug" greatly aids the body in fighting to kill the invading *tubercle bacilli*. INAH and PAS, initials for drugs with jaw-breaking names, also serve as heavy artillery against the invader. New and better surgical techniques also help to make the fight a shorter and more successful one. But rest and good care, with body and strength building diet, still hold their place in the battle line.

BCG

The American public has been hearing recently of an anti-TB vaccine, called BCG, which has been in use rather extensively in some foreign countries for decades. The vaccine is not regarded highly in the United States. It is not condemned by our best authorities, but rather, its effectiveness and practicability are questioned.

Perhaps the attitude of Florida's tuberculosis fighters can best be reflected in a report issued by the National Tuberculosis Association July 15, 1956 which says, in effect, that (1) BCG offers protection only to those not already infected with tubercle bacilli; (2) most of our new tuberculosis cases come from the 30 per cent of our population already infected; (3) the number of new infections each year is small, therefore, the number of cases prevented by vaccination would be small; (4) tuberculosis cases are decreasing substantially each year *without* a vaccination program; (5) the duration of protection from BCG is probably five years or less; (6) BCG does not protect against infection with virulent tubercle bacilli, but seems to protect against progression of new infections; (7) BCG produces sensitivity to tuberculin so the tuberculin test loses its diagnostic value after vaccination; and (8) BCG is not without some danger. Local abscesses

This is one of the mobile units which are constantly traveling about the state in the search for tuberculosis cases. Nearly 800 cases were uncovered in 1957 by the mobile units.

MANY TIMES a chest X-ray has provided information other than whether a subject has tuberculosis. Other diseases of the chest cavity such as heart conditions and tumors have been discovered. Conditions, which if left undiscovered, would eventually cause serious illness or death, have been brought to the attention of the subject and his physician. The chest X-ray campaigns have helped many people in Florida in this way, making it possible for them to receive needed attention before unknown diseases or conditions have gotten out of hand.

RADIATION FEARS EXAGGERATED

The fear of radiation has stemmed from the geneticists' fear of gonadal (reproductive organs) radiation as it applies to future generations of the entire population. If an X-ray machine is properly calibrated and shielded it has been shown that the amount of radiation ot the gonads will be much less than the maximum permitted by the International Commission on Radiation Protection. Insofar as the public health is concerned chest X-ray surveys should be considered a relatively safe procedure.

Total Cases and Deaths from Tuberculosis with Rates per 100,000 Population, Florida

YEAR	POPULATION	CASES	RATE PER 100,000 POP.	DEATHS	RATE PER 100,000 POP.
1917	912,886			1,085	118.9
1922	1,090,359			1,019	93.5
1927	1,334,134			1,097	82.2
1932	1,528,000			1,093**	71.5
1937	1,736,984			985	56.7
1942	2,055,675			867	42.2
1947	2,483,200			796	32.1
1952	3,006,400	2,603	86.6	501	16.7
1957	4,250,400	2,414	56.8	257*	6.0

* (Resident deaths 1933-1957)

** (Recorded deaths 1917-1932)

are frequent and occasional deaths occur. It is a live organism vaccine.

AFTER THE HOSPITAL

The directors of the 66 County Health Departments, the public health nurses, the private physicians, state and private welfare agencies and voluntary health agencies—are all frequently involved with the discharged tuberculosis patient, just as they were when the case was first discovered. If the patient was the breadwinner in the family before he became ill, the intervening months have probably been pretty bad for the family. Public health workers, though not directly involved in solutions of these problems are daily in contact with them and see their impact on the community.

But it is the disease, not the individual patient, which concerns us now. As soon as the patient is released from the hospital, he becomes again the concern of the local health department, for his case is going to require months or even years of medication and supervision before he is entirely on his own again. The public health nurse from the County Health Department will now become a familiar sight—and in most instances a good friend—to the family of the released tuberculosis patient. Her visits will be many during the next few months. Her concern will not only include the patient, but the family also—have they had their X-rays to make sure they have not contracted the disease?

In some cases, she will find the patient working full-time at his previous job. At the other extreme, she will have patients who have been told to continue their bed rest and drug therapy at home. And in between will be all sorts of variations. Each will have rules of life to follow. These are sometimes irksome rules, for the discharged patient

"The state's tuberculosis control program has made a lot of progress in the past ten years. With modern hospitals, new drugs and advanced surgical techniques along with a better understanding of the disease, we have, indeed, forged ahead. But our goal—the elimination of tuberculosis—is beyond the horizon. Our present situation and our present need are clearly before us. There is no place in the picture for false optimism. We must continue our present program with all possible vigor. Where the community-wide X-ray survey plan has served its purpose we must shift our emphasis to selective X-ray examination or the tuberculin testing program, as the need may be indicated. But whatever the method, we must search and seek, treat, care for, and rehabilitate the victims of tuberculosis in our state until that unforeseeable day when we can close our hospitals, dismantle our clinics and turn our faces toward other horizons. That, I think, is something only future generations will see."

C. M. SHARP, M.D., *Director*
Bureau of Preventable Diseases
Florida State Board of Health

often has a false sense of strength and well-being. The private physician, the public health nurse, or the health officer, will have to be stern, kind, authoritative and compassionate all at once. For they are the guides on the road to final recovery and good health.

So it will be also with the other people involved with the patient—his employer, physician, minister, members of the family. All will have to use their patience and understanding to the fullest. It is a happy thing to report that in the large majority of cases these helpers do their job well, and thousands of former patients are now leading happy, useful, near normal lives.

WHERE WE FIT IN

We, the people of Florida, are fortunate. We have a good public health program. We have County Health Departments in 66 of our 67 counties. There is an excellent voluntary organization, the Florida Tuberculosis and Health Association, which has 56 organized county associations and 11, which are unorganized, that have seal sale committees. Our long range campaign against tuberculosis is equal to the best, and our success is assured—if we follow our leaders.

The state's program to combat and eliminate tuberculosis needs first of all the continued financial support of our representatives in state and national government, but it directly involves us as citizens of the community in its case-finding program. As has been mentioned before, the program must now be extended to include—to find and bring to treatment—persons who have never been contacted before. These are the people on the fringes of organized society, who have little contact with the organized cooperative efforts of that society.

The jailers can X-ray the jailed, hospitals can X-ray all patients who are admitted, the visible and audible pleas of TV, radio, pamphlets, exhibits and posters can bring in many people to the mobile X-ray trailers. But the isolated, the untaught, the shy and reluctant can be brought in only through the individual efforts of people they know and trust. We must bring them in. For the sake of our own health, and that of our community, we must find these people and bring them to treatment. They constitute Florida's reservoir of tuberculosis, and ours will not be the Florida we want it to be until this reservoir is drained.

WHAT HAPPENED TO THE HUNCHBACKS?

Stop and think a minute. What HAS happened to the hunchbacks who were a fairly common sight in our grandfather's day? People with otherwise normal

appearing faces and forms, but whose backs were hunched away up and who thus appeared shorter than the average are practically gone from the American scene. Why? Because tuberculosis of the bone is almost a thing of the past.

Pulmonary or lung tuberculosis has demanded most of our attention in this article, but another form of the disease, tuberculosis of the bone, is worthy of mention too.

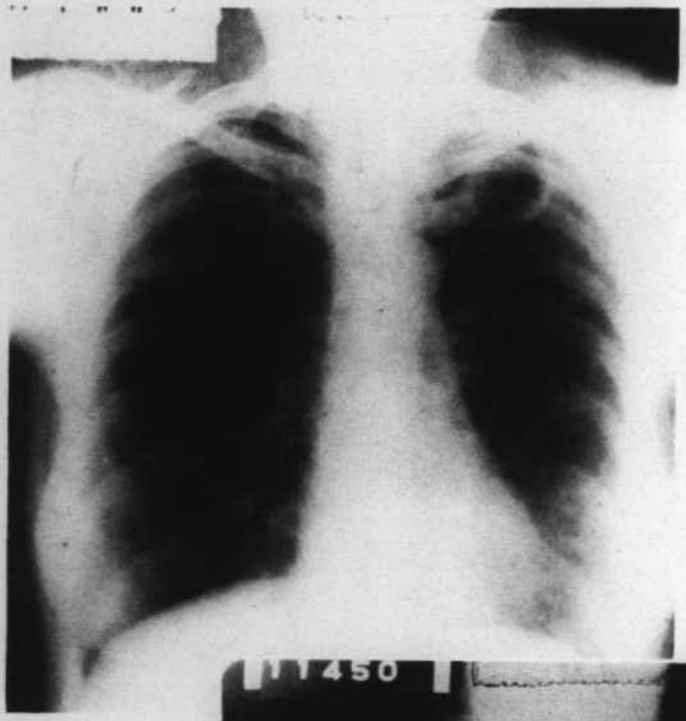
Until about a generation ago all milk was not pasteurized, and all dairy herds were not tuberculin tested. Bovine tuberculosis, a form of the disease now quite rare in this country, was fairly common and these infected cows transmitted their disease to many who drank their milk. Rather than attacking the lungs of human beings, it affected the bones, and less frequently other body tissues. If the germ found its way to the spine of the victim a couple of vertebrae would become diseased, collapse, and the condition we know as hunchback would result. The medical term was Potts' Disease.

The same germ often attacked other portions of the body. Stiffened hips and knees, crippling people for life, resulted from tuberculosis of the joints. The eyes were not immune, nor even the brain. Tuberculous meningitis was considered a surely fatal disease a few years ago. Now it is still a serious disease, but some victims recover if diagnosed and treated early. Meningitis means infection in the outer lining of the brain, and a tubercular infection in such a vital spot is serious indeed. The disease is fortunately rare now. Bovine tuberculosis has been practically eliminated by drastic culling of dairy herds and stringent control laws.

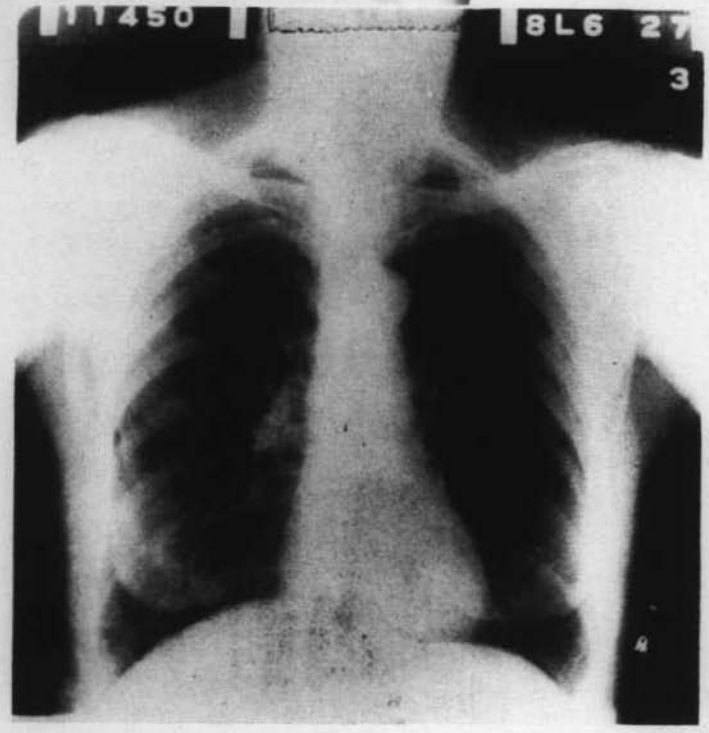
Animals and TB

TUBERCULOSIS in the animal world is not an important factor in the human tuberculosis picture, but it is worthy of comment. Tuberculin testing of milk herds and pasteurization of milk have eliminated man's greatest source of infection from animals. But the animals we most frequently contact do occasionally have the disease, and some authorities advise against keeping pets in a family where active tuberculosis exists. These animals are the cat, dog and parrot or parakeet, and the domestic farm animals, the cow, pig and chicken. Animals known to have had contact with a tuberculosis animal or human should be kept away from contact with other animals or humans, and examined by a veterinarian. It should be noted that wild animals of all kinds, particularly monkeys, are known to suffer from the disease.

These People Just Stopped By For An X-ray



This chest is diseased by tuberculosis. The cavity in the upper right lung (facing you) indicates that the baccilli have attacked the lung tissues.



This is a healthy chest. There is no cavity area nor the hazy "snowstorm" seen in in the above diseased chest.

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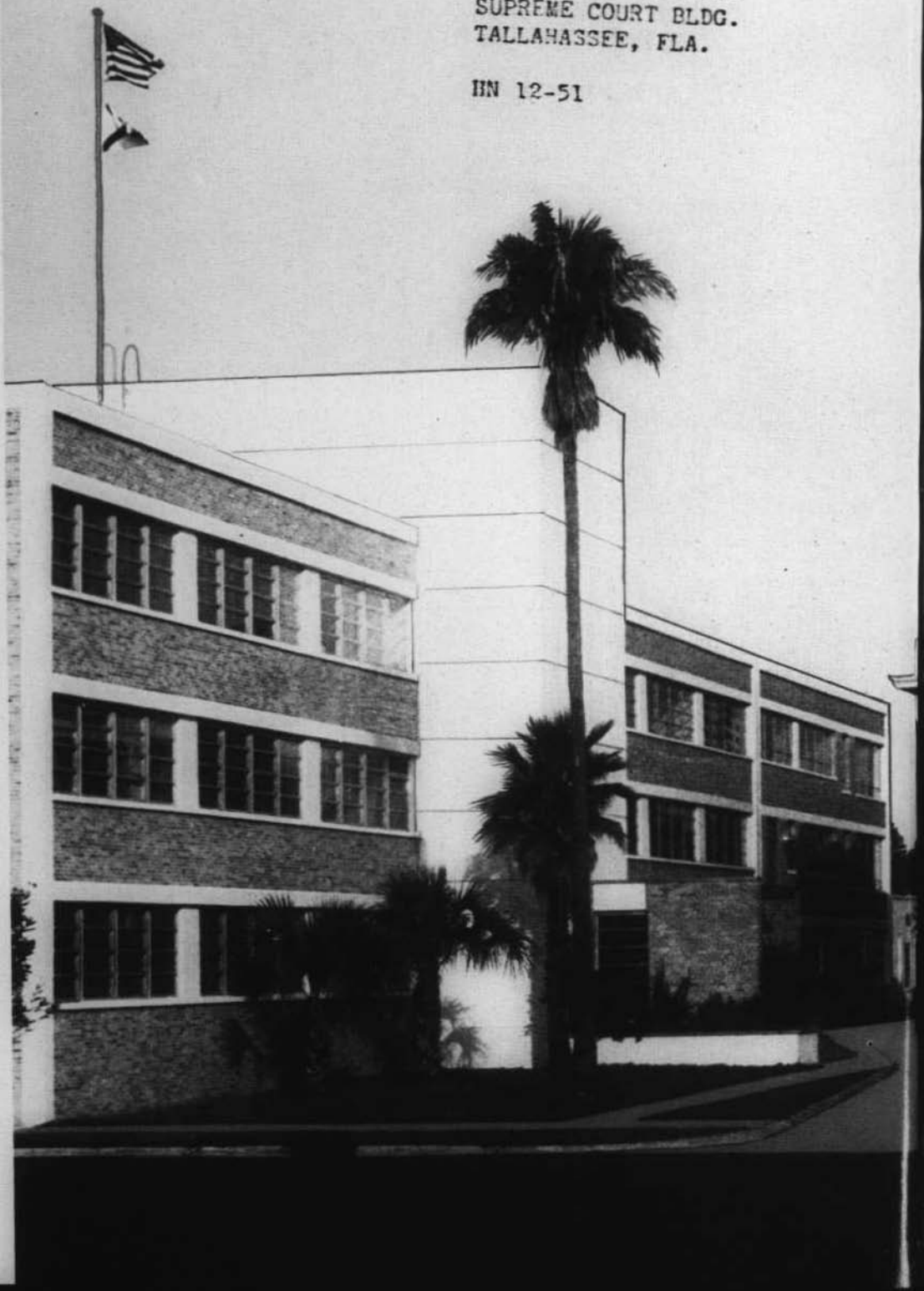
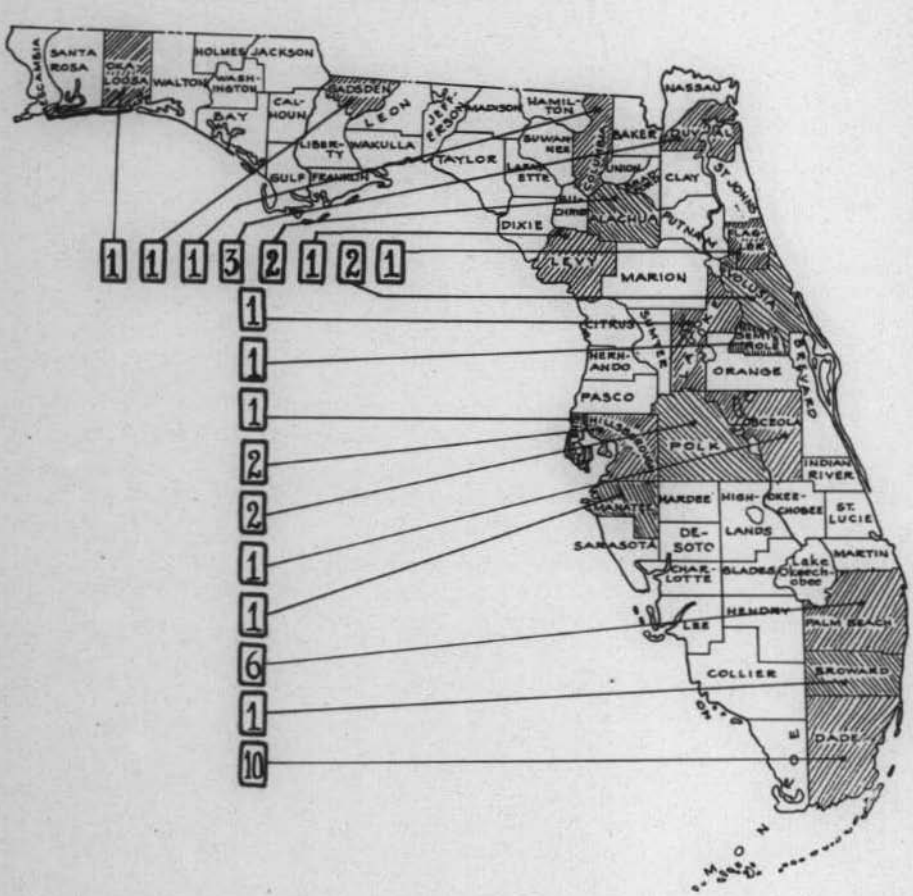


Florida HEALTH NOTES

DECEMBER, 1958
VOLUME 50 • NO. 10

TETANUS—KILLER

Where Tetanus Deaths Occurred In Florida in 1957



LIKE TO MAKE A GUESS as to the three greatest killers among the *preventable diseases* in Florida? You think tuberculosis is first? You're right. Don't know the second? It's syphilis. And you needn't even try to guess the third because it would probably never enter your mind that it was a major killer: TETANUS! In spite of the fact that you can be protected against tetanus (lockjaw) through immunizing shots, 64 Floridians were treated for tetanus in 1957—and 38 of them died. That made it 60 per cent fatal, for approximately two out of three persons who contracted tetanus died of it. And death from lockjaw is not an easy one. An added note is that there were more deaths from tetanus in Florida in 1957 than there were from polio. Makes you stop and think, doesn't it?

Why is lockjaw so dangerous? Because it often enters the body unnoticed, lies low or masks its symptoms until it is too late to turn it back from its often fatal outcome.

The tetanus (lockjaw) spore or germ can enter the body through the most insignificant cut or scratch. A look at some of the ways people contracted tetanus in Florida last year reveals that in many cases the person attacked was not too sure just what might have been the source of infection. In one case a woman stuck the point of a fishhook in her hand and later died of the infection. A small boy accidentally hit his younger brother in the head with a garden hoe. The brother later died of tetanus. A young mother died as a result of scratching her foot on a piece of wire in her yard. The well-known classical rusty nail, so often pictured in connection with lockjaw, accounted for only nine of the 38 deaths.

Other causes noted were: a young woman died as a result of a tetanus infection as an aftermath of an illegal abortion. Chronic skin ulcers which got tetanus germs in them accounted for two deaths: one man stepped on a rake, while another cut himself while paring his toenails. One man died as a result of a splinter in his finger while others were divided among a variety

of cuts, lacerations and abrasions. Among the more unusual were cases involving insect stings, scratches from cactus and other thorns, and getting stuck on or by brush, branches, Spanish bayonet spikes or fences.

The deaths of 11 newborn babies from tetanus in 1957 was a cause for concern. Five of these babies were delivered at home by midwives, two were delivered at home by physicians, three were delivered in hospitals or clinics and in one case, no information was available. It is believed that the lockjaw germs entered through the umbilical cord after it was cut. Some typical reports made by investigating public health nurses include the following remarks: cord was cut with an old pair of scissors and tied with household string; baby found in very dirty bedding; cobwebs were used to stop the cord from bleeding; a nickel and a button were taped directly on to the navel.

All of these eleven babies were given hospital care as soon as they were discovered to be ill. Unfortunately, no treatment could help them for they were found too late—and they all died.

ALL ABOUT THE VILLAIN

Tetanus doesn't operate like many other germs. That's because it is an organism that lives only on dead cells rather than a parasite which thrives only on living cells. This fact keeps lockjaw from killing more people than it does, for unless there are dead cells present when the spores enter the body it usually just dies and we do not realize we were hosts to such a terrible germ.

The tetanus germ is actually a spore forming bacteria called a saprophyte. Saprophytes are micro-organisms that live and grow in dead and decayed matter, as distinguished from parasites, which live and grow in living matter.

Lockjaw spores are found universally in the soil. Since there is more dank and rotted vegetation in the tropical areas than in the colder climates there are more spores to be found in the warmer parts of the nation. This may account for the fact that Florida leads the nation in deaths from lockjaw..

If you work with flowers, dig in the yard, like outdoor sports, work as a carpenter or laborer, or even go outside your house you are exposing yourself to infection by lockjaw. The spores are everywhere and they wait patiently on rusty nails, fishhooks,

FLORIDA HEALTH NOTES

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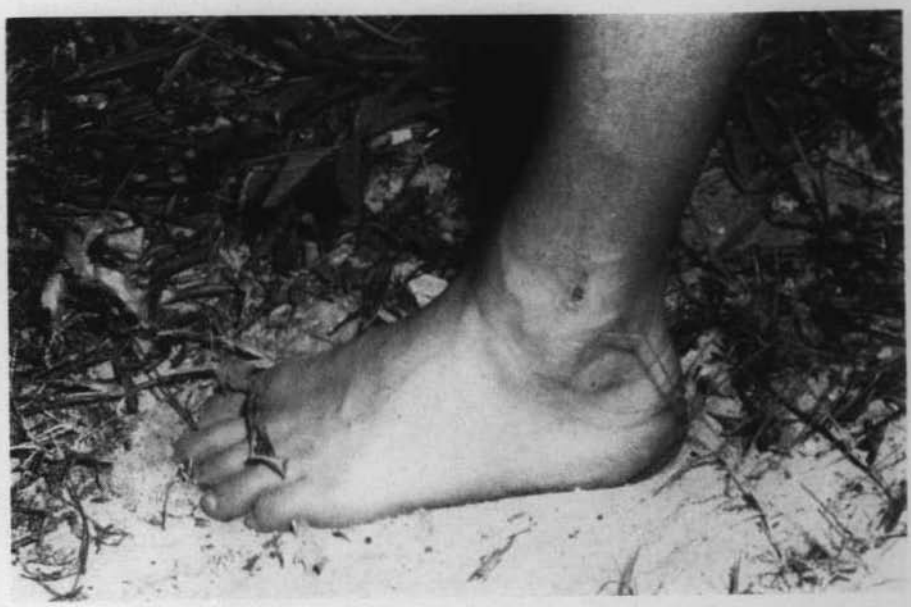
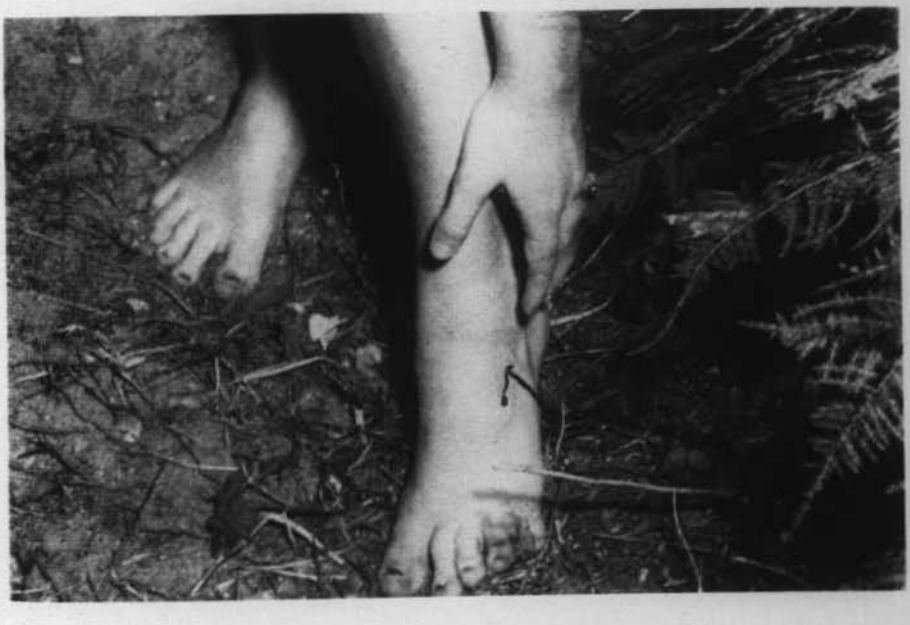
A Twig Sticks into a Foot . . .

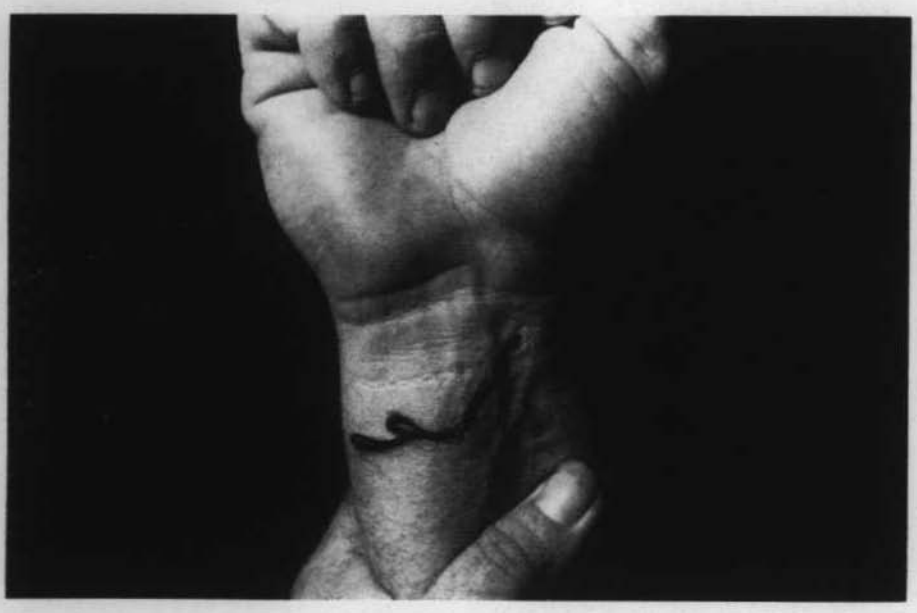


. . . an Ulcer May Pick up a Tetanus Germ



A Spanish Bayonet Spike Causes a Wound . . .

. . . a Cut on the Arm Can Let in Germs



pieces of fence wire, twigs that stick into your skin and dirt that gets into ulcerated sores on hands, arms and feet. (Don't be frightened—later on we will tell you how you can enjoy all these activities without worrying.)

Once the spores have entered through an insignificant scratch or an abrasion they attach themselves firmly and begin to grow. Unlike other germs, the lockjaw spores rarely leave the place where they enter the body. They do not get into the bloodstream and spread to other parts of the body. Instead, they begin secreting a toxin, or poison that travels along the nerves, paralyzing them as they go. It eventually works its way up to the heart and lungs. These organs then become paralyzed, and death occurs. The fact that usually the jaws become paralyzed is where the disease derived the name of *lockjaw*. Convulsions also occur frequently.

Fortunately, enough symptoms may occur before a deadly dose of the toxin has affected the nervous system and antitoxin may be used to counteract the toxin and save the victim's life. However, if a sufficient quantity of the toxin has been liberated it cannot be neutralized by any quantity of the presently known antitoxin. For this reason, victims who have waited too long to seek treatment are faced with certain death.

DON'T TAKE CHANCES

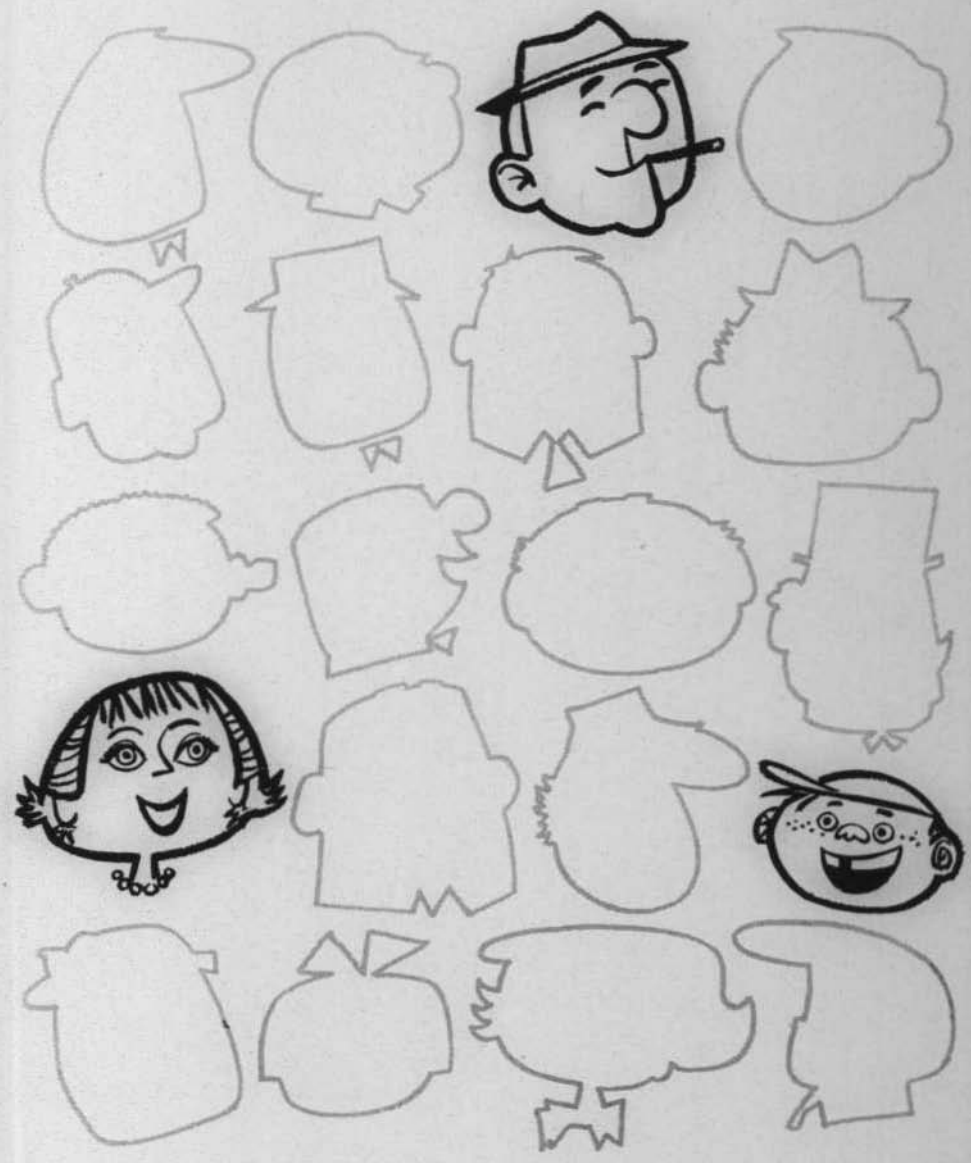
From the foregoing it can readily be seen that no matter how insignificant the injury is, it must be treated if one is to avoid the possibility of tetanus infection. Of course, the most positive way of avoiding tetanus is by *immunization*. You merely see your doctor and he will give you a shot. Thirty days later you will get a second shot and at the end of twelve months, you get the third one. From then on every three to five years a single booster shot is usually sufficient to maintain your immunity to lockjaw. Statistics show that this immunization is more than 95 per cent effective. If there is any question as to whether or not you should take such shots, your doctor will advise you.

Of course, first aid should be given to all cuts and wounds—as all of us have been taught to do. But in case you wish to refresh your memory:

Simple precautions are usually enough, and they are extremely simple. First, wash the wound with soap and clean water. Water alone is not enough—a good soap is also important since it cleans the dirt *and the tetanus spores* from the injury. After washing thoroughly then apply a good antiseptic and bandage the wound to prevent more dirt or contamination from entering.

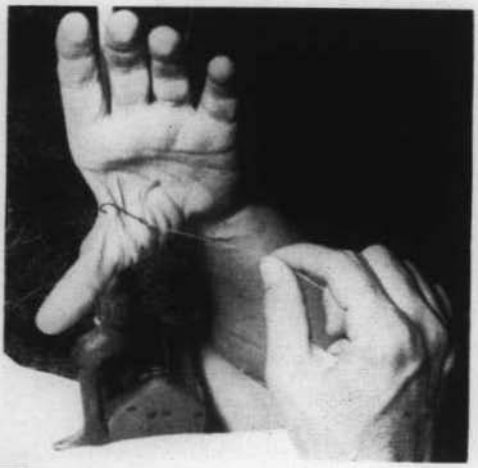
ALL OF THESE PEOPLE SHOULD HAVE HAD TETANUS SHOTS....

ARE YOU AMONG THE MISSING ?



A

Fishhook . . .



A

Piece of

Wire . . .

. . . Or the
Proverbial
Rusty Nail . . .
All Can Harbor
Tetanus Germs

If you step on a nail or have any type of deep puncture wound you should go to your doctor or a hospital clinic right away. It is not usually possible for you to clean a deep puncture properly and the doctor will probably give you a shot of tetanus antitoxin or toxoid right away—to prevent lockjaw—in the event the wound has been difficult to clean.

There is no accurate way to find out how many people have been immunized against tetanus. Judging from county health department records and estimates made by private physicians, probably not more than one-third of Florida's people have been protected against this disease.

A BACKWARD LOOK

Many men and women who served in the armed forces were given regular shots for tetanus (among other things). It is curious to note that in only one case of the 38 who died in 1957 was there a record that the individual had received immunizations while in the armed forces, and this was ten years prior to his death. Apparently his was the only case reported which involved a former serviceman. Does this indicate that the men and women who served in the armed forces are still retaining some degree of immunization even though they have not maintained their booster shots with regularity? Perhaps so, say the researchers, but they have drawn no specific conclusion and will not commit themselves. However, they do know that previous war records show the extreme value of immunizations.

In World War I, the rate of tetanus infection was alarmingly high. In 1914 the British Army recorded that of every 1,000 injuries, nine cases of tetanus developed. The British medical department began giving antitetanus toxoid to every man wounded regardless of the severity of the wound. The tetanus cases dropped dramatically. One year later the rate was only one case of tetanus in every 2000 injuries or 0.5 per cent. In June, 1917, it was ordered that each wounded man receive not one but four inoculations at the rate of one shot each week.

As a result of studying the British experience, the American Army began a schedule of antitoxin inoculations that called for one thousand units each seven days under certain conditions. The inoculations were to be given to all wounded men, also to those who developed a form of athlete's foot called "trench-foot," in cases of frost bite, where operations were performed under unsatisfactory cleanliness conditions on the battlefield, where wounds were received seven days prior to treatment, or when any operation or injury had to be opened for treatment,

regardless of the length of time since date of injury. The American Army was taking no chances on lockjaw infections!

As a result, there were 36 cases of lockjaw reported out of 176,-132 battlefield injuries. Since World War I, tetanus immunizations have been standard procedure in the armed forces.

FLORIDA FACTS

Florida has the highest tetanus death rate in the nation.

It is curious to note that it is not the farm dweller but the city resident who seems to be hit hardest by tetanus. The figures indicate that three times as many cases were reported among city people as those living in suburban areas; and the figure for city people is nine time greater than those living in rural areas. This might come as a surprise to some readers, since we ordinarily connect tetanus with farming and the barnyard.

Of the 38 deaths from tetanus in 1957, the highest number of total deaths occured during the first month of life; in short, newborn babies. There were 11 deaths in this group of which three were white and eight non-white. The next largest group to feel the force of the disease was in the 45 to 64 age category. There were 10 deaths in this age group: three white and seven non-white. There were six deaths in the 20 to 44 age group and five for the over-65 age group.

(The Florida Times Union)

TAMPAN DIES OF TETANUS

TAMPA, Sept. 23 (AP)—A 45-year-old Tampa man died last night of tetanus, believed to have been contracted while transplanting shrubs from rusty cans.

Police said doctors diagnosed tetanus when Raul Perez was admitted to a hospital Sept. 14, He said he cut his finger while setting out the shrubs about Sept. 1, but did nothing about it. Hospital attendants said efforts to save Perez were unavailing because of the illness' two-week head start.

The largest number of deaths fell among the non-white males with a total of 18 of the 38 deaths happening among this group alone. Non-white females followed next with nine deaths, followed closely by the white males with eight deaths and the white female with three.

The deaths occurred in 18 different counties (see map on inside of front cover) although seven of the counties had 70 per cent (27) of the deaths. Dade, Palm Beach and Duval had the largest number of deaths followed closely by Alachua, Hillsborough, Polk and Volusia counties with two each, and the remaining 11 counties recording only single cases. Over the years the southeastern coastal counties have consistently reported more tetanus cases than the remainder of the state.

A Cut in the Shop Can Lead to Trouble

WHAT YOU CAN DO

The Florida State Board of Health, in its fight against the dread lockjaw disease—tetanus:

▸ Urges all expectant mothers to be immunized against tetanus. The effects of the immunization will carry over for the first month of the baby's life. At the end of the thirty-day period the mother can see that the baby begins its own series of immunizations, and lessen the danger for the ensuing years.

▸ Points out that all children under school age should be under the care of their private physician or attend a well-baby conference in their community. The physician will advise concerning protecting the child against a number of diseases: diphtheria, whooping cough, polio, smallpox—and tetanus.

▸ Emphasizes the fact that booster shots for tetanus should be given every three to five years. Keep a record on your child. Check on his immunizations regularly.

▸ Advises all adults to be protected against tetanus. Look upon these immunizing shots as you would on your insurance policies. You wouldn't let them lapse, would you?

▸ Requests that you inquire if there are hospital facilities available in your community for all maternity cases, regardless of color. Unfortunately, a large number of our infant deaths are among those families who depend on someone to deliver their babies at home. This is a problem that can be solved only by education of the expectant parents to seek and find adequate hospital care at the time of delivery; and by better education and control of midwives who still serve areas with poor hospital facilities.

If you follow the above suggestions, you will never need to see — or hear about — even one distressing death from tetanus.

Two Kinds Of Protection

Two types of tetanus-fighting shots are given and there exists some confusion among the public as to just which is which.

The first, tetanus toxoid, is a shot given to immunize a person on a long-term basis. That part of the vaccine which is used for injection has the power to create antibodies in the blood stream which fight off the tetanus germs when an injury occurs. If injured, the person who has had the toxoid immunization (two shots) is given another shot called a "booster" which reinforces the shots already given. If no injury is suffered, the toxoid shots should be "boosted" every three to five years.

The second, known as tetanus antitoxin, is a shot adminstered to those persons who have not had toxoid injections who have suffered an injury where there is a danger of tetanus. This serum works much faster than the toxoid since the need for it is immediate. However, the antitoxin is made of horse serum and the doctors prefer not to use it except in cases where no previous immunization has been given.

The immunity of antitoxin lasts only two to three weeks, while the immunity given by tetanus toxoid lasts for several years.

First Aid

For cuts, scratches, abrasions or any wound other than a puncture wound, such as stepping on a nail, *wash the wound with soap and clean water*. This washes away the tetanus spores and is better than trying to kill them inside the wound.

There is usually a bottle of peroxide around most homes. Peroxide is good for flushing out the wound *after* the soap and water have been used. Tetanus spores are of a type that live better and thrive better *without* oxygen. Since peroxide contains more oxygen than water it has the effect of helping to kill off the spores. Iodine, which is also usually found in most homes, helps keep down the likelihood of getting lockjaw since it kills other bacteria that might also have entered the wound and which might assist the tetanus spores in getting a foothold in your body.

For puncture wounds, especially those that are deep and hard to cleanse, the surface may be washed off with soap and water but since it is extremely difficult to get into the hole created by the puncture the victim should be taken to the doctor *immediately*. The incubation period, during which time the spores establish themselves and begin to secrete their deadly poison, is very short and no time should be wasted. The symptoms of lockjaw infection might show up anywhere from three to ten days after the wound. In a great many cases it is too late to do the victim any good after the symptoms show up.

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